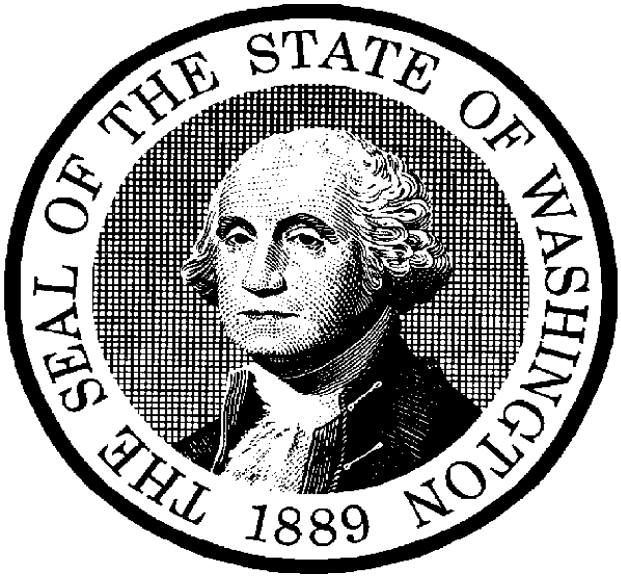
Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration



Ambulatory Surgery Centers

Billing Instructions

July 2000

Current Procedure Terminology CPT

About this publication

This publication supersedes all previous billing instructions for Ambulatory Surgery Centers.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
July 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

Applying for a provider

Call:
Provider Enrollment Unit
(800) 562-6188 and
Select Option #1

or call one of the following numbers:

(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Call:
Provider Relations Unit (PRU)
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Write/call:
Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
(800) 562-6136

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Ambulatory Surgery Center (ASC) - Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Categorically Needy (CNP) - CNP programs are the federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for:

- CNP only;
- Cash benefits under the SSI (Supplemental Security Income);
- TANF (Temporary Assistance for Needy Families);
- General Assistance – X (special); or
- General Assistance (children's).

CNP includes full scope coverage for pregnant women and children.

Client – An applicant approved for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Coinsurance-Medicare – The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges. (WAC 388-500-0005)

Core Provider Agreement - A basic contract that the Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Current Procedural Terminology (CPT™) – A description of medical procedures available from the American Medical Association of Chicago, Illinois.

Deductible-Medicare – An initial specified amount that is the responsibility of the client.

- **Part A of Medicare-Inpatient Hospital Deductible -** An initial amount of the medical care cost in each benefit period which Medicare does not pay.

- **Part B of Medicare-Physician Deductible** - An initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay. (WAC 388-500-0005)

Department - The state Department of Social and Health Services. (WAC 388-500-0005)

Expedited Prior Authorization (EPA) - The process of authorizing selected services in which providers use a set of numeric codes to indicate to MAA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Health Care Financing Administration Common Procedure Coding System (HCPCS) – Coding system established by the Health Care Financing Administration to define services and procedures.

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) cards – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients will receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

a) First and middle initials (a dash (-) must be used if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha character (tiebreaker).

Primary Care Case Manager (PCCM) – A physician, Advanced Registered Nurse Practitioner, or Physician Assistant who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small, monthly, management fee.

Prior Authorization – Approval required from MAA prior to providing services, for certain medical services, equipment, or supplies based on medical necessity.

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Field Services;
- Managed Care Contracts;
- Provider Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number – A seven-digit identification number issued to providers who have signed the appropriate contract(s) with MAA.

Remittance And Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

State Unique Procedure Code(s) – MAA procedure code(s) used for a specific service(s) where there is not a CPT, Health Care Financing Administration's Common Procedure Coding System (HCPCS), or CDT code available or appropriate.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual and Customary Fee – The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

Ambulatory Surgery Centers

What is the purpose of the Ambulatory Surgery Centers Program?

The purpose of the Ambulatory Surgery Centers (ASC) Program is to reimburse providers for the facility costs of surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgery center.

Who should use these billing instructions?

Ambulatory Surgery Centers that have a valid Core Provider Agreement with MAA should use these billing instructions.

Client Eligibility

Eligibility

Most medical assistance clients are eligible for Ambulatory Surgery Center services **except** clients presenting Medical Assistance IDentification (MAID) cards with one of the following identifiers:

Exceptions:

MAID Identifier	Medical Program
CNP-Emergency Medical Only	**Categorically Needy Program-Emergency Medical Only** – These clients are not eligible for Ambulatory Surgery Center services.
Emergency Hospital and Ambulance Only	**Medically Indigent Program** - These clients are not eligible for Ambulatory Surgery Center services.
LCP-MNP – Emergency Medical Only	**Limited Casualty Program – Medically Needy Program – Emergency Medical Only –** These clients are not eligible for Ambulatory Surgery Center services.
Family Planning Only	**Family Planning** – These clients may receive only sterilization services.

Are clients enrolled in managed care eligible for Ambulatory Surgery Center services?

Clients with an identifier in the HMO column on their MAID card are enrolled in one of MAA's Healthy Options managed care plans. The client's managed care plan covers services provided at ambulatory surgery centers when the client's Primary Care Provider (PCP) determines that the services are appropriate for the client's health care needs. You must bill the plan directly.

To prevent billing denials, please check the client's MAID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or plan.

Primary Care Case Management (PCCM) clients will have the identifier PCCM in the HMO column on their MAID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the HCFA-1500 claim form. (See the *Billing* section for further information.)

Coverage

What is covered?

MAA covers the procedure codes listed in these billing instructions when medically necessary and not solely for cosmetic treatment or surgery.

> ☞ **Note:** Authorization requirements or diagnoses may limit coverage of some procedures. When there are requirements, there is a notation below the CPT code description.

What procedures have special limitations?

- The physician performing the surgery for procedures with special limitations must:

  ✓ Meet the special limitation requirements; and/or
  ✓ Obtain prior authorization through either the Limitation Extension or Expedited Prior Authorization process.

  When billing MAA, the ASC must include this information on the HCFA-1500 claim form.

Continued on next page ⟶

- MAA allows the following surgeries only when the diagnosis is V10.3, 140-239.9, 757.6, 906.5-9, or 940-949.5.

CPT™ Codes	Description
11960	Insertion of tissue expander(s)
11970	Replacement of tissue expander w/permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
19160	Mastectomy, partial;
19162	with axillary lymphadenectomy
19180	Mastectomy, simple, complete
19182	Mastectomy, subcutaneous
19316	Mastopexy
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy, or in reconstruction
19342	Delayed insertion breast prosthesis
19350	Nipple/areola reconstruction
19357	Breast reconstruction w/tissue expander
19364	Breast reconstruction/free flap
19366	Breast reconstruction w/other technique
19370	Open periprosthetic capsulotomy, breast
19371	Periprosthetic capsulectomy, breast
19380	Revision of reconstructed breast

- MAA allows the following surgeries only when the diagnosis is 605, 607.1, or 607.81.

CPT™ Codes	Description
54152	Circumcision, using clamp or other device; except newborn.
54161	Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn.

- MAA covers medically necessary cataract removal when the client has one of the following:

  ✓ Correctable visual acquity in the affected eye at 20/50 or worse as measured on the Snellen test chart; or

  ✓ One or more of the following conditions:

  - Dislocated or subluxated lens;
  - Intraocular foreign body;
  - Ocular trauma;
  - Phacogenic glaucoma;
  - Phacogenic uveitis;
  - Phacoanaphylactic endopthalmitis; or
  - Senescent cataract.

- MAA covers prior authorized cochlear implants. To receive prior authorization through the Limitation Extension process, a provider must send or fax a request for authorization along with medical justification to:

Division of Health Services Quality Support
Quality Fee for Service Section
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

The request must contain all of the following:

1) The name and PIC number of the client;
2) The provider's name and provider number;
3) The name of the facility where surgery will be performed;
4) The service being requested, including CPT procedure code;
5) A list of the client's diagnoses;
6) A complete evaluation from a multiple disciplinary cochlear implant team addressing, at a minimum, the following:

   a) Team recommendation;
   b) Evaluation of family expectations, compliance, motivation and exposure to all potential forms of communication;
   c) Medical clearance for surgery-no contraindications to surgery;
   d) Documentation that hearing is amenable to cochlear implants;
   e) Evidence of failed hearing aids if appropriate. If not appropriate, a brief note as to why hearing aides are not appropriate in this individual case; and
   f) Proposed post op rehabilitation program and location of rehabilitation services.

☞ **Note:** MAA will request additional information as needed.

Expedited Prior Authorization

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

To bill MAA for services that meet the expedited prior authorization (EPA) criteria on the following pages, the provider must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000.** The last 3 digits must be the code number that qualifies the procedure for the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the ***Authorization Number*** field or in the ***Authorization*** or ***Comments*** field when billing electronically.

Example: The 9-digit EPA number for reduction mammoplasties in a client with hypertrophy of the breast that meets all of the EPA criteria would be **870000241** (870000 = first 6 digits, 241 = diagnostic condition or procedure code).

EPA numbers are not valid for:

- Services for which the documented medical condition does not meet all of the specified criteria; or
- Services that are limited by diagnosis; or
- Services not allowed in an ambulatory surgery center.

Expedited Prior Authorization Guidelines:

A. **Medical Justification (criteria)** - All information must come from the client's prescribing provider. MAA will not accept information obtained from the client or someone on behalf of the client (e.g. family).

B. **Documentation** - The ASC **must keep** documentation that meets the criteria in the client's file. This documentation must be readily available for inspection by MAA staff conducting a pre-pay or post-pay audit. Keep documentation on file for six (6) years.

☞ **Note:** Upon audit, if **all** specified criteria are not met, MAA has the authority to recoup any payments made. (WAC 388-087-010)

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria

REDUCTION MAMMOPLASTIES/MASTECTOMY FOR GYNECOMASTIA

CPT Code: 19318, 19140 Associated ICD-9-CM Diagnosis codes 611.1 (Hypertrophy of Breast) or 611.9 (Gynecomastia)

241 Diagnosis for **hypertrophy of the breast** with:

1) Photographs and client's chart; and

2) Documented medical necessity including:

   a) Back, neck, and/or shoulder pain for a minimum of one year, directly attributable to macromastia; and
   b) Conservative treatment not effective; and

3) Abnormally large breasts in relation to body size with shoulder grooves; and

4) Within 20% of ideal body weight; and

5) Verification of minimum removal of 500 grams of tissue from each breast.

242 Diagnosis for **gynecomastia**:

1) Pictures in client's chart; and

2) Persistent tenderness and pain; and

3) If history of drug or alcohol abuse, must have abstained from drug or alcohol use for no less than one year.

OTHER REDUCTION MAMMOPLASTIES/MASTECTOMY FOR GYNECOMASTIA

250 Reduction mammoplasty or mastectomy, not meeting expedited prior authorization criteria, but medically necessary as clearly evidenced by the information in the client's medical record.

Code	Criteria

BLEPHAROPLASTIES
CPT Code: 67901 - 67924

630 Blepharoplasty for noncosmetic reasons when both of the following are true:

1) The excess upper eyelid skin impairs the vision by blocking the superior visual field; and

2) On a central visual field test, the vision is blocked to within 10 degrees of central fixation.

STRABISMUS SURGERY
CPT Code: 67311 - 67340

631 Strabismus surgery for clients 18 years of age and older when both of the following are true:

1) The client has double vision; and

2) It is not done for cosmetic reasons.

Reimbursement

What is included in the facility payment?

The facility payment maximum allowable includes:

- The client's use of the facility, including the operating room and recovery room;
- Nursing services, technician services, and other related services;
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment related to the care provided;
- Diagnostic or therapeutic items and services directly related to the surgical procedure;
- Administrative, recordkeeping and housekeeping items and services; **and**
- Materials and supplies for anesthesia.

Facility fee when multiple surgical procedures are performed

✓ For providers performing multiple surgical procedures in a single operative session, MAA reimburses 100 percent of the department allowable of the procedure with the highest group number. For the second procedure, reimbursement is 50 percent of the department allowable. MAA does not make additional reimbursement for subsequent procedures.

✓ The provider must identify the:

- Primary procedure (the procedure with the highest reimbursement rate) with modifier **5A; and**
- Secondary procedure with modifier **5B**.

What is not included in the facility payment?

The following services are not included in the facility payment:

- Physicians' professional services;
- The sale, lease, or rental of durable medical equipment to clients for use in their homes;
- Prosthetic devices (e.g., intraocular lens);
- Ambulance or other transportation services;
- Leg, arm, back, and neck braces; **and**
- Artificial legs, arms, and eyes.

Billing

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ☞ **Note:** If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date the plan recouped the payment from the provider.

  ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

  - ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

For the client who has chosen to obtain care with a Primary Care Case Manager (PCCM), the identifier in the HMO column will be "PCCM." These clients must obtain their services through the PCCM. The PCCM is responsible for coordination of care just like the PCP is in a plan setting. Please refer to the client's MAID card for the PCCM.

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

Newborns of Healthy Options clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen. These services must be billed to MAA.

☞ **Note:** If you treat a Healthy Options client who has chosen to obtain care with a PCCM and you are not the PCP, or the client was not referred to you by the PCCM/PCP, you may not receive payment. You will need to contact the PCP to get a referral.

How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

☞ **Note:** Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.

☞ **Note:** A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

(Clients who have CNP or MNP identifiers on their MAID card in addition to QMB)

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

- If only Medicaid **and not Medicare** cover the service and the service is covered under the CNP or MNP program, MAA will reimburse for the service.

QMB-Medicare Only

- If Medicare **and** Medicaid cover the service, MAA will pay only the deductible and/or coinsurance up to Medicare or Medicaid's allowed amount, whichever is less.

- If only Medicare **and not Medicaid** covers the service, MAA will pay only the deductible and/or coinsurance up to Medicare's allowed amount.

Note: For QMB-Medicare Only: If **Medicare** does not cover the service, MAA will not reimburse the service.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept?

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.**

How do I bill for sterilization procedures?

- Federal regulations prohibit MAA from processing claims for sterilization procedures without a completed consent form. ASCs, surgeons, anesthesiologists, and assistant surgeons must attach a copy of the completed consent form to their claim; copies may be obtained from the physician who performs the sterilization. A sample of the consent form is on page 25. See page 23 to request the form.
- A claim for a sterilization procedure received without a consent form will be denied.
- An incomplete consent form will be returned to the provider and the claim will be denied.
- The signature and other information on the consent must be legible.
- Submit the claim and completed consent form to:

DIVISION OF PROGRAM SUPPORT
PO BOX 9248
OLYMPIA WA 98507-9248

☞ **Note:** The DSHS 13-364x Consent Form and regulations for sterilization are the same for fee-for-service and Healthy Options providers. Healthy Options providers must send the Sterilization Consent Form, with attachments as applicable, directly to their Licensed Health Carrier for billing purposes, rather than to MAA.

Sterilization Procedures and CPT Codes:

Procedure	Associated CPT Codes
Vasectomy	55250
Tubal Ligation	58600, 58615, 58670, 58671

Physician Signature Clarification:

The physician identified in the *Consent to Sterilization Section* of the DSHS 13-364x Consent Form must be the same physician who completes the *Physician's Statement Section* and performs the sterilization procedure. If the physician who signed the above referenced sections of the Consent Form is not the physician performing the sterilization procedure, the client must sign and date a new Consent Form indicating the name of the physician performing the operation under the *Consent for Sterilization Section*, at the time of the procedure. Staple this modified consent form to the initial Consent Form.

Consent Requirements:

- Submit a completed Consent Form, DSHS 13-364x, with the claim.
- Consent must be voluntary.
- The client must be at least 18 years old when the consent form is signed.
- For clients 18 through 20 years old, modify the DSHS 13-364x Consent Form by crossing out 21 in the following three places on the form and writing in the correct age:
  - ✓ *Consent to Sterilization Section* - **"I am at least ~~21~~"**
  - ✓ *Statement of Person Obtaining Consent Section* - **"is at least ~~21~~"**
  - ✓ *Physician's Statement Section* - **"is at least ~~21~~"**
- The client must sign the consent form at least 30 days, but no more than 180 days, prior to surgery. Consent expires after 180 days.
- The physician must sign the consent form after, or not more than one week before, surgery.
- If the Medical Assistance IDentification (MAID) card shows delayed or retroactive certification, all of the above criteria must still be met.

What about clients who have no consent form?

For clients who are mentally incompetent or institutionalized, MAA requires a court order and a DSHS 13-364x signed by the client's legal guardian at least 30 days prior to the surgery.

For clients under 18 years of age, who have received retroactive certification, or who have received delayed certification, providers must obtain a letter of exception from MAA's Medical Director. Send your request to:

MEDICAL ASSISTANCE ADMINISTRATION
MEDICAL DIRECTOR
PO BOX 45500
OLYMPIA, WA 98504-5500

Write or fax your request for the DSHS 13-354x Consent Form to:

DSHS WAREHOUSE
PO BOX 45816, OLYMPIA WA 98504-5816
FAX (360) 664-0597

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Sample Sterilization Policy and Consent Form

Sample Sterilization Policy and Consent Form

Sample Spanish Sterilization Policy and Consent Form

Sample Spanish Sterilization Policy and Consent Form

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, PCCM, Medicare, Indian Health, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

17. **Name of Referring Physician or Other Source**: When applicable. Enter the referring physician or Primary Care Case Manager name.

17a. **I.D. Number of Referring Physician**: Enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved for local use**: When applicable, enter additional information such as indicator "B" to indicate baby on parent's PIC.

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization Number for Limitation Extensions:** When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 04, 2000 = 040400). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. Enter **3** (ambulatory surgery center).

24C. **Type of Service**: Required. Enter **Z** (ambulatory surgery center).

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate CPT or HCFA Common Procedure Coding System (HCPCs) or state unique procedure code from the fee schedule in these billing instructions for the services being billed. **MODIFIER** – When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: Required. Enter the appropriate number of units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number**: Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

PIN: Enter the seven-digit number assigned to you by MAA here.

Sample HCFA-1500 Form

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	Please Enter:
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach MAA?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the words, *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form. Be sure the Medicare denial letter or EOMB is attached to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card consisting of:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., July 4, 2000 = 040400). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. Enter **3** (ambulatory surgery center).

24C. **Type of Service**: Required. Enter **Z** (ambulatory surgery center).

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCs) procedure code for the services being billed. **Coinsurance and Deductible**: Enter the total combined coinsurance and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: Required. Enter the appropriate number of units.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Enter the occupational therapy clinic or individual number assigned to you by MAA.

Sample Medicare Part B/Medicaid Crossover Form

Fee Schedule

The Medical Assistance Administration (MAA) uses Medicare's guidelines to identify and group surgery procedures that are appropriate in a freestanding ambulatory surgery center setting. In addition, MAA uses procedure codes not covered by Medicare but grouped using Medicare's guidelines. These procedures have been classified into eight groups. A single maximum allowable for the facility fee has been established for each group as follows. Providers must bill professional fees separately.

Group	July 1, 2002 Maximum Allowable
1	$302.21
2	$332.71
3	$359.38
4	$407.17
5	$437.93
6	$490.50
7	$552.79
8	$634.52

MAA covers only the procedure codes listed on the attached fee schedule in ambulatory surgery centers.

Continued on next page ⟶

CPT Procedure Code	Description	Group

INTEGUMENTARY SYSTEM

SKIN, SUBCUTANEOUS AND AREOLAR TISSUES

INCISION

10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	2
10080	Incision and drainage of pilonidal cyst; simple	2
10081	complicated	2
10121	Incision and removal of foreign body, subcutaneous tissues; complicated	2
10140	Incision and drainage of hematoma, seroma or fluid collection	2
10180	Incision and drainage, complex, postoperative wound infection	2

EXCISION - DEBRIDEMENT

11001	Debridement of extensive eczematous or infected skin; each additional 10% of the body surface	2
11042	Debridement; skin, and subcutaneous tissue	2
11043	skin, subcutaneous tissue, and muscle	2
11044	skin, subcutaneous tissue, muscle, and bone	2

REMOVAL OF SKIN TAGS

11200	Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions	2

EXCISION - BENIGN LESIONS

11401	Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm	1
11402	lesion diameter 1.1 to 2.0 cm	1
11403	lesion diameter 2.1 to 3.0 cm	1
11404	lesion diameter 3.1 to 4.0 cm	1
11406	lesion diameter over 4.0 cm	2
11421	Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm	1
11422	lesion diameter 1.1 to 2.0 cm	2
11423	lesion diameter 2.1 to 3.0 cm	2
11424	lesion diameter 3.1 to 4.0 cm	2
11426	lesion diameter over 4.0 cm	2
11441	Excision, other benign lesion (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm	1
11442	lesion diameter 1.1 to 2.0 cm	1
11443	lesion diameter 2.1 to 3.0 cm	1
11444	lesion diameter 3.1 to 4.0 cm	1
11446	lesion diameter over 4.0 cm	2
11450	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair	2
11451	with complex repair	2
11462	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair	2
11463	with complex repair	2
11470	Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair	2
11471	with complex repair	2

EXCISION - MALIGNANT LESIONS

11601	Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.6 to 1.0 cm	1
11602	lesion diameter 1.1 to 2.0 cm	1
11603	lesion diameter 2.1 to 3.0 cm	1
11604	lesion diameter 3.1 to 4.0 cm	2
11606	lesion diameter over 4.0 cm	2
11624	Excision, malignant lesion, scalp, neck, hands, feet, genitalia; lesion diameter 3.1 to 4.0 cm	2
11626	lesion diameter over 4.0 cm	2
11640	Excision, malignant lesion, face, ears, eyelids, nose, lips; lesion diameter 0.5 cm or less	1
11641	lesion diameter 0.6 to 1.0 cm	1
11642	lesion diameter 1.1 to 2.0 cm	1
11643	lesion diameter 2.1 to 3.0 cm	1
11644	lesion diameter 3.1 to 4.0 cm	2
11646	lesion diameter over 4.0 cm	2

CPT Procedure Code	Description	Group

NAILS

11750	Excision of nail and nail matrix, partial or complete, (eg, ingrown or deformed nail) for permanent removal	1
11762	Reconstruction of nail bed with graft	2
11770	Excision of pilonidal cyst or sinus; simple	3
11771	extensive	3
11772	complicated	3

INTRODUCTION

11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion. **LIMITED BY DIAGNOSIS.**	2
11970	Replacement of tissue expander with permanent prosthesis. **LIMITED BY DIAGNOSIS**	3
11971	Removal of tissue expander(s) without insertion of prosthesis. **LIMITED BY DIAGNOSIS.**	1

REPAIR (CLOSURE)

REPAIR - SIMPLE

12005	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	2
12006	20.1 cm to 30.0 cm	2
12007	over 30.0 cm	2
12016	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm	2
12017	20.1 cm to 30.0 cm	2
12018	over 30.0 cm	2
12020	Treatment of superficial wound dehiscence; simple closure	1
12021	with packing	1

REPAIR - INTERMEDIATE

12034	Layer closure of wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm	2
12035	12.6 cm to 20.0 cm	2
12036	20.1 cm to 30.0 cm	2
12037	over 30.0 cm	2
12044	Layer closure of wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm	2
12045	12.6 to 20.0 cm	2
12046	20.1 cm to 30.0 cm	2
12047	over 30.0 cm	2
12054	Layer closure of wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 7.6 cm to 12.5 cm	2
12055	12.6 cm to 20.0 cm	2
12056	20.1 cm to 30.0 cm	2
12057	over 30.0 cm	2

REPAIR - COMPLEX

13100	Repair, complex, trunk; 1.1 cm to 2.5 cm	2
13101	2.6 cm to 7.5 cm	3
13102	each additional 5 cm or less	4
13120	Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm	2
13121	2.6 cm to 7.5 cm	3
13122	each additional 5 cm or less	4
13131	Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm	2
13132	2.6 cm to 7.5 cm	3
13133	each additional 5 cm or less	4
13150	Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less	3
13151	1.1 cm to 2.5 cm	3
13152	2.6 cm to 7.5 cm	3
13153	each additional 5 cm or less	4
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated	2

ADJACENT TISSUE TRANSFER OR REARRANGEMENT

14000	Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less	2
14001	defect 10.1 sq cm to 30.0 sq cm	3
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less	3
14021	defect 10.1 sq cm to 30.0 sq cm	3

CPT Procedure Code	Description	Group
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less	2
14041	defect 10.1 sq cm to 30.0 sq cm	3
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less	3
14061	defect 10.1 sq cm to 30.0 sq cm	3
14300	Adjacent tissue transfer or rearrangement, more than 30 sq cm, unusual or complicated, any area	4
14350	Filleted finger or toe flap, including preparation of recipient site	3
	FREE SKIN GRAFTS	
15000	Surgical preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft)	2
15050	Pinch graft, single or multiple, to cover small ulcer, tip of digit, or other minimal open area (except on face), up to defect size 2 cm diameter	2
15100	Split graft, trunk, scalp, arms, legs; 100 sq cm or less, or each one percent of body area of infants and children (except 15050)	2
15101	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof	3
15120	Split graft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; 100 sq cm or less, or each one percent of body area of infants and children (except 15050)	2
15121	each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof	3
15200	Full thickness graft, free, including direct closure of donor site, trunk; 20 sq cm or less	3
15201	each additional 20 sq cm	2
15220	Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm of less	2
15221	each additional 20 sq cm	2
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 20 sq cm or less	3
15241	each additional 20 sq cm	3
15260	Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less	2
15261	each additional 20 sq cm	2
15350	Application of allograft, skin; 100 sq. cm or less.	2
15400	Application of xenograft, skin; 100 sq. cm or less.	2
	FLAPS (SKIN AND/OR DEEP TISSUES)	
15570	Formation of direct or tubed pedicle, with or without transfer; trunk	3
15572	scalp, arms, or legs	3
15574	forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet	3
15576	eyelids, nose, ears, lips or intraoral	3
15600	Delay of flap or sectioning of flap (division and inset); at trunk	3
15610	at scalp, arms, or legs	3
15620	at forehead, cheeks, chin, neck, axillae, genitalia, hands, or feet	4
15630	at eyelids, nose, ears, or lips	3
15650	Transfer, intermediate, of any pedicle flap (eg, abdomen to wrist, Walking tube), any location	5
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter, sternocleidomastoid, levator scapulae)	3
15734	trunk	3
15736	upper extremity	3
15738	lower extremity	3
	OTHER FLAPS AND GRAFTS	
15740	Flap; island pedicle	2
15750	neurovascular pedicle	2
15756	Free muscle flap with or without skin with microvascular anastomosis	3
15757	Free skin flap with microvascular anastomosis	3

CPT Procedure Code	Description	Group
15758	Free fascial flap with microvascular anastomosis	3
15760	Graft; composite (full thickness of external ear or nasal ala), including primary closure, donor area	2
15770	derma-fat-fascia	3
	OTHER PROCEDURES	
15840	Graft for facial nerve paralysis; free fascia graft (including obtaining fascia)	4
15841	free muscle graft (including obtaining graft)	4
15842	free muscle graft by microsurgical technique	4
15845	regional muscle transfer	4
15851	Removal of sutures under anesthesia (other than local), other surgeon	4
	PRESSURE ULCERS (DECUBITUS ULCERS)	
15920	Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture	3
15922	with flap closure	4
15931	Excision, sacral pressure ulcer, with primary suture;	3
15933	with ostectomy	3
15934	Excision, sacral pressure ulcer, with skin flap closure;	3
15935	with ostectomy	4
15936	Excision, sacral pressure ulcer, in preparation for muscle or myocutaneous flap or skin graft closure;	4
15937	with ostectomy	4
15940	Excision, ischial pressure ulcer, with primary suture;	3
15941	with ostectomy (ischiectomy)	3
15944	Excision, ischial pressure ulcer, with skin flap closure;	3
15945	with ostectomy	4
15946	Excision, ischial pressure ulcer, with ostectomy, in preparation for muscle or myocutaneous flap or skin closure	4
15950	Excision, trochanteric pressure ulcer, with primary suture;	3
15951	with ostectomy	4
15952	Excision, trochanteric pressure ulcer, with skin flap closure;	3
15953	with ostectomy	4
15956	Excision, trochanteric pressure ulcer, in preparation for muscle or myocutaneous flap closure;	3
15958	with ostectomy	4
	BURNS, LOCAL TREATMENT	
16015	Dressing and/or debridement, initial or subsequent; under anesthesia, medium or large, or with major debridement	2
16030	without anesthesia, large (eg, more than one extremity)	1
16035	Escharotomy	2

BREAST

INCISION

19020	Mastotomy with exploration or drainage of abscess, deep	2

EXCISION

19100	Biopsy of breast; needle core	1
19101	incisional	2
19110	Nipple exploration, with or without excision of a solitary lactiferous duct or a papilloma lactiferous duct	2
19112	Excision of lactiferous duct fistula	3
19120	Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19140), male or female, one or more lesions	3
19125	Excision of breast lesion identified by preoperative placement of radiological marker; single lesion	3
19126	each additional lesion separately identified by a radiological marker	3

CPT Procedure Code	Description	Group
19140	Mastectomy for gynecomastia **EXPEDITED PRIOR AUTHORIZATION REQUIRED.**	4
19160	Mastectomy, partial; **LIMITED BY DIAGNOSIS**	3
19162	with axillary lymphadenectomy **LIMITED BY DIAGNOSIS**	7
19180	Mastectomy, simple, complete **LIMITED BY DIAGNOSIS**	4
19182	Mastectomy, subcutaneous **LIMITED BY DIAGNOSIS**	4
19260	Excision of chest wall tumor including ribs	5
19290	Preoperative placement of needle localization wire, breast;	1
19291	each additional lesion	1
	REPAIR AND/OR RECONSTRUCTION	
19316	Mastopexy **LIMITED BY DIAGNOSIS**	3
19318	Reduction mammaplasty **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	4
19328	Removal of intact mammary implant	1
19330	Removal of mammary implant material	1
19340	Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction. **LIMITED BY DIAGNOSIS**	3
19342	Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction. **LIMITED BY DIAGNOSIS**	3
19350	Nipple/areola reconstruction **LIMITED BY DIAGNOSIS**	4
19357	Breast reconstruction, immediate or delayed with tissue expander, including subsequent expansion. **LIMITED BY DIAGNOSIS**	5
19364	Breast reconstruction with free flap **LIMITED BY DIAGNOSIS**	5
19366	Breast reconstruction with other technique **LIMITED BY DIAGNOSIS**	5
19370	Open periprosthetic capsulotomy, breast **LIMITED BY DIAGNOSIS**	4
19371	Periprosthetic capsulectomy, breast **LIMITED BY DIAGNOSIS**	4
19380	Revision of reconstructed breast **LIMITED BY DIAGNOSIS**	5

MUSCULOSKELETAL SYSTEM

GENERAL

INCISION

20005	Incision of soft tissue abscess (eg, secondary to osteomyelitis); deep or complicated	2

EXCISION

20200	Biopsy, muscle; superficial	2
20205	deep	3
20206	Biopsy, muscle, percutaneous needle	1
20220	Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)	1
20225	deep (vertebral body, femur)	2
20240	Biopsy, excisional; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)	2
20245	deep (eg, humerus, ischium, femur)	3
20250	Biopsy, vertebral body, open; thoracic	3
20251	lumbar or cervical 3	

INTRODUCTION OR REMOVAL

20525	Removal of foreign body in muscle or tendon sheath; deep or complicated	3
20650	Insertion of wire or pin with application of skeletal traction, including removal	3
20660	Application of cranial tongs, caliper, or stereotactic frame, including removal	2
20661	Application of halo, including removal; cranial	3
20662	pelvic	3
20663	femoral	3

CPT Procedure Code	Description	Group
20665	Removal of tongs or halo applied by another physician	1
20670	Removal of implant; superficial, (eg, buried wire, pin or rod)	1
20680	deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)	3
20690	Application of a uniplane (pins or wires in one plane), unilateral, external fixation system	2
20694	Removal, under anesthesia, of external fixation system	1
	GRAFTS (OR IMPLANTS)	
20900	Bone graft, any donor area; minor or small (eg, dowel or button)	3
20902	major or large	4
20910	Carilage graft; costochondral	3
20912	nasal septum	3
20920	Fascia lata graft; by stripper	4
20922	by incision and area exposure, complex or sheet	3
20924	Tendon graft, from a distance (eg, palmaris, toe extensor, plantaris)	4
20926	Tissue grafts, other (eg, paratenon, fat, dermis)	4
	OTHER PROCEDURES	
20955	Bone graft with microvascular anastomosis; fibula	4
20962	other bone graft (specify)	4
20969	Free osteocutaneous flap with microvascular anastomosis; other than iliac crest, rib, metatarsal, or great toe	4
20970	Free osteocutaneous flap with microvascular anastomosis; iliac crest	4
20972	metatarsal	4
20973	great toe with web space	4
20975	Electrical stimulation to aid bone healing; invasive (operative).	2

CPT Procedure Code	Description	Group
	HEAD	
	INCISION	
21010	Arthrotomy, temporomandibular joint	2
	EXCISION	
21025	Excision of bone (eg, for osteomyelitis or bone abscess); mandible	2
21026	facial bone(s)	2
21034	Excision of malignant tumor of facial bone other than mandible	3
21040	Excision of benign cyst or tumor of mandible; simple	2
21041	complex	2
21044	Excision of malignant tumor of mandible	2
21050	Condylectomy, temporomandibular joint	3
21060	Meniscectomy partial or complete, temporomandibular joint	2
21070	Coronoidectomy	3
	INTRODUCTION OR REMOVAL	
21100	Application of halo type appliance for maxillofacial fixation, includes removal	2
	REPAIR, REVISION, AND/OR RECONSTRUCTION	
21206	Osteotomy, maxilla, segmental (eg, Wassmund or Schuchard)	5
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)	7
21209	reduction	5
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)	7
21215	mandible (includes obtaining graft)	7
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft)	7
21235	ear cartilage, autogenous, to nose or ear (includes obtaining graft)	7
21240	Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft)	4

CPT Procedure Code	Description	Group
21242	Arthroplasty, temporomandibular joint, with allograft	5
21243	Arthroplasty, temporomandibular joint, with prosthetic joint replacement	5
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (eg, mandibular staple bone plate)	7
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial	7
21246	complete	7
21248	Reconstruction of mandible or maxilla, endosteal implant (eg, blade, cylinder); partial	7
21249	complete	7
21267	Orbital repositioning, periorbital osteotomies, unilateral, with bone graft; extracranial approach	7
21270	Malar augmentation, prosthetic material	5
21275	Secondary revision of orbitocraniofacial reconstruction	7
21280	Medial canthopexy	5
21282	Lateral canthopexy	5
	FRACTURE AND/OR DISLOCATION	
21300	Closed treatment of skull fracture without operation	2
21310	Closed treatment of nasal bone fracture without manipulation	2
21315	Closed treatment of nasal bone fracture; without stabilization	2
21320	with stabilization	2
21325	Open treatment of nasal fracture; uncomplicated	4
21330	complicated, with internal and/or external skeletal fixation	5
21335	with concomitant open treatment of fractured septum	7
21337	Closed treatment of nasal septal fracture, with or without stabilization	2
21338	Open treatment of nasoethmoid fracture; without external fixation	4
21339	with external fixation	5
21340	Percutaneous treatment of nasoethmoid complex fracture, with splint, wire or headcap fixation, including repair of canthal ligaments and/or the nasolacrimal apparatus	4
21343	Open treatment of depressed frontal sinus fracture	5
21355	Percutaneous treatment of fracture of malar area, including zygomatic arch and malar tripod, with manipulation	3
21360	Open treatment of depressed malar fracture, including zygomatic arch and malar tripod	4
21365	Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with internal fixation and multiple surgical approaches	5
21385	Open treatment of orbital floor "blowout" fracture; transantral approach (Caldwell-Luc type operation)	5
21386	periorbital approach	5
21387	combined approach	5
21390	periorbital approach, with alloplastic or other implant	7
21395	periorbital approach with bone graft (includes obtaining graft)	7
21400	Closed treatment of fracture of orbit, except "blowout"; without manipulation	2
21401	with manipulation	3
21406	Open treatment of fracture of orbit, except "blowout"; without implant	4
21407	with implant	5
21421	Closed treatment of palatal or maxillary fracture (LeFort I type), with interdental wire fixation or fixation of denture or splint	4
21422	Open treatment of palatal or maxillary fracture (LeFort I type)	5
21440	Closed treatment of mandibular or maxillary alveolar ridge fracture	3
21445	Open treatment of mandibular or maxillary alveolar ridge fracture	4
21450	Closed treatment of mandibular fracture; without manipulation	3

CPT Procedure Code	Description	Group
21451	with manipulation	4
21452	Percutaneous treatment of mandibular fracture, with external fixation	2
21453	Closed treatment of mandibular fracture with interdental fixation	3
21454	Open treatment of mandibular fracture with external fixation	5
21461	Open treatment of mandibular fracture; without interdental fixation	4
21462	with interdental fixation	5
21465	Open treatment of mandibular condylar fracture	4
21470	Open treatment of complicated mandibular fracture by multiple surgical approaches including internal fixation, interdental fixation, and/or wiring of dentures or splints	5
21480	Closed treatment of temporomandibular dislocation; initial or subsequent	1
21485	complicated (eg, recurrent requiring intermaxillary fixation or splinting), initial or subsequent	2
21490	Open treatment of temporomandibular dislocation	3
21493	Closed treatment of hyoid fracture; without manipulation	3
21494	with manipulation 4	
21495	Open treatment of hyoid fracture	4
21497	Interdental wiring, for condition other than fracture	2

NECK (SOFT TISSUES) AND THORAX

INCISION

21501	Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax;	2
21502	with partial rib ostectomy	2
21510	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), thorax	3

EXCISION

21550	Biopsy, soft tissue of neck or thorax	1
21555	Excision tumor, soft tissue of neck or thorax; subcutaneous	2
21556	deep, subfascial, intramuscular	2
21600	Excision of rib, partial	2
21610	Costotransversectomy	2
21620	Ostectomy of sternum, partial	2

REPAIR, REVISION, AND/OR RECONSTRUCTION

21700	Division of scalenus anticus; without resection of cervical rib	2
21720	Division of sternocleidomastoid for torticollis, open operation; without cast application	3
21725	with cast application	3

FRACTURE AND/OR DISLOCATION

21800	Closed treatment of rib fracture, uncomplicated, each	1
21805	Open treatment of rib fracture without fixation, each	2
21810	Treatment of rib fracture requiring external fixation ("flail chest")	2
21820	Closed treatment of sternum fracture	1

BACK AND FLANK

EXCISION

21920	Biopsy, soft tissue of back or flank; superficial	1
21925	deep	2
21930	Excision, tumor, soft tissue of back or flank	2
21935	Radial resection of tumor (eg, malignant neoplasm), soft tissue of back or flank	3

SPINE (VERTEBRAL COLUMN)

EXCISION

22100	Partial resection of vertebral component, spinous processes; cervical	3
22101	thoracic	3
22102	lumbar	3
22103	each additional segment	3

CPT Procedure Code	Description	Group
	FRACTURE AND/OR DISLOCATION	
22305	Closed treatment of vertebral process fracture(s)	1
22310	Closed treatment of vertebral body fracture(s), without manipulation	1
22315	Closed treatment of vertebral fracture and/or dislocation requiring casting or bracing, with or without anesthesia, by manipulation or traction, each	2
22325	Open treatment of vertebral fracture and/or dislocation; lumbar, each	3
22326	cervical, each	3
22327	thoracic, each	3
22328	each additional fractured vertebrae or dislocated segment	3
	MANIPULATION	
22505	Manipulation of spine requiring anesthesia, any region	2
	ABDOMEN	
	EXCISION	
22900	Excision, abdominal wall tumor, subfascial (eg, desmoid)	4
	SHOULDER	
	INCISION	
23000	Removal of subdeltoid (or intratendinous) calcareous deposits, open method	2
23020	Capsular contracture release (Sever type procedure)	2
23030	Incision and drainage, shoulder area; deep abscess or hematoma	1
23035	Incision, deep, with opening of cortex (eg, osteomyelitis or bone abscess), shoulder area	3
23040	Arthrotomy, glenohumeral joint, for infection, with exploration, drainage or removal of foreign body	3
23044	Arthrotomy, acromioclavicular, sternoclavicular joint, for infection, with exploration, drainage or removal of foreign body	4

CPT Procedure Code	Description	Group
	EXCISION	
23065	Biopsy, soft tissue of shoulder area; superficial	1
23066	deep	2
23075	Excision, tumor, shoulder area; subcutaneous	2
23076	deep, subfascial or intramuscular	2
23077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of shoulder area	3
23100	Arthrotomy with biopsy, glenohumeral joint	2
23101	Arthrotomy with biopsy or with excision of torn cartilage, acromioclavicular, sternoclavicular joint	7
23105	Arthrotomy with synovectomy; glenohumeral joint	4
23106	sternoclavicular joint	4
23107	Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body	4
23120	Claviculectomy; partial	5
23125	total	5
23130	Acromioplasty or acromionectomy, partial	5
23140	Excision or curettage of bone cyst or benign tumor of clavicle or scapula;	4
23145	with autograft (includes obtaining graft)	5
23146	with allograft	5
23150	Excision or curettage of bone cyst or benign tumor of proximal humerus;	4
23155	with autograft (includes obtaining graft)	5
23156	with allograft	5
23170	Sequestrectomy (eg, for osteomyelitis or bone abscess), clavicle	2
23172	Sequestrectomy (eg, for osteomyelitis or bone abscess), scapula	2
23174	Sequestrectomy (eg, for osteomyelitis or bone abscess), humeral head to surgical neck	2
23180	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis), clavicle	4

CPT Procedure Code	Description	Group
23182	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis), scapula	4
23184	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis), proximal humerus	4
23190	Ostectomy of scapula, partial (eg, superior medial angle)	4
23195	Resection humeral head	5
REMOVAL		
23330	Removal of foreign body, shoulder; subcutaneous	1
23331	deep (eg, Neer prosthesis removal)	1
REPAIR, REVISION OR RECONSTRUCTION		
23395	Muscle transfer, any type, shoulder or upper arm; single	5
23397	multiple	7
23400	Scapulopexy (eg, Sprengel's deformity or for paralysis)	7
23405	Tenomyotomy, shoulder area; single	2
23406	multiple through same incision	2
23410	Repair of ruptured musculotendinous cuff (eg, rotator cuff); acute	5
23412	chronic	7
23415	Coracoacromial ligament release, with or without acromioplasty	5
23420	Repair of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)	7
23430	Tenodesis of long tendon of biceps	4
23440	Resection or transplantation of long tendon of biceps	4
23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation	5
23455	Bankart type operation with or without stapling	7
23460	Capsulorrhaphy, anterior, any type; with bone block	5
23462	with coracoid process transfer	7
23465	Capsulorrhaphy for recurrent dislocation, posterior, with or without bone block	5
23466	Capsulorrhaphy with any type multi-directional instability	7
23480	Osteotomy, clavicle, with or without internal fixation;	4
23485	with bone graft for nonunion or malunion (includes obtaining graft and/or necessary fixation)	7
23490	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate; clavicle	3
23491	proximal humerus and humeral head	3
FRACTURE AND/OR DISLOCATION		
23500	Closed treatment of clavicular fracture; without manipulation	1
23505	with manipulation	1
23515	Open treatment of clavicular fracture, with or without internal or external fixation	3
23520	Closed treatment of sternoclavicular dislocation; without manipulation	1
23525	with manipulation	1
23530	Open treatment of sternoclavicular dislocation, acute or chronic	3
23532	with fascial graft (includes obtaining graft)	4
23540	Closed treatment of acromioclavicular dislocation; without manipulation	1
23545	with manipulation	1
23550	Open treatment of acromioclavicular dislocation, acute or chronic;	3
23552	with fascial graft (includes obtaining graft)	4
23570	Closed treatment of scapular fracture; without manipulation	1
23575	with manipulation, with or without skeletal traction (with or without shoulder joint involvement)	1
23585	Open treatment of scapular fracture (body, glenoid or acromion) with or without internal fixation	3

CPT Procedure Code	Description	Group
23600	Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation	1
23605	with manipulation with or without skeletal traction	2
23615	Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(-ies);	4
23616	with proximal humeral prosthetic replacement	4
23620	Closed treatment of greater tuberosity fracture; without manipulation	1
23625	with manipulation	2
23630	Open treatment of greater tuberosity fracture, with or without internal or external fixation	5
23650	Closed treatment of shoulder dislocation, with manipulation; without anesthesia	1
23655	requiring anesthesia	1
23660	Open treatment of acute shoulder dislocation	3
23665	Closed treatment of shoulder dislocation, with fracture of greater tuberosity, with manipulation	2
23670	Open treatment of shoulder dislocation, with fracture of greater tuberosity, with or without internal or external fixation	3
23675	Closed treatment of shoulder dislocation, with surgical or anatomical neck fracture, with manipulation	2
23680	Open treatment of shoulder dislocation, with surgical or anatomical neck fracture, with or without internal or external fixation	3
MANIPULATION		
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)	1
ARTHRODESIS		
23800	Arthrodesis, shoulder joint; with or without local bone graft	4
23802	with primary autogenous graft (includes obtaining graft)	7
AMPUTATION		
23921	Disarticulation of shoulder; secondary closure or scar revision	3

HUMERUS (UPPER ARM) AND ELBOW

CPT Procedure Code	Description	Group
INCISION		
23930	Incision and drainage, upper arm or elbow area; deep abscess or hematoma	1
23931	infected bursa	2
23935	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), humerus or elbow	2
24000	Arthrotomy, elbow, for infection, with exploration, drainage or removal of foreign body	4
EXCISION		
24065	Biopsy, soft tissue of upper arm or elbow area; superficial	1
24066	deep	2
24075	Excision, tumor, upper arm or elbow area; subcutaneous	2
24076	deep, subfascial or intramuscular	2
24077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of upper arm or elbow area	3
24100	Arthrotomy, elbow; with synovial biopsy only	1
24101	with joint exploration, with or without biopsy, with or without removal of loose or foreign body	4
24102	with synovectomy	4
24105	Excision, olecranon bursa	3
24110	Excision or curettage of bone cyst or benign tumor, humerus;	2
24115	with autograft (includes obtaining graft)	3
24116	with allograft	3
24120	Excision or curettage of bone cyst or benign tumor of head or neck of radius or olecranon process;	3

CPT Procedure Code	Description	Group
24125	with autograft (includes obtaining graft)	3
24126	with allograft	3
24130	Excision, radial head	3
24134	Sequestrectomy (eg, for osteomyelitis or bone abscess), shaft or distal humerus	2
24136	Sequestrectomy (eg, for osteomyelitis or bone abscess), radial head or neck	2
24138	Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process	2
24140	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis), humerus	3
24145	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis), radial head or neck	3
24147	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis), olecranon process	2
24150	Radical resection for tumor, shaft or distal humerus;	3
24151	with autograft (includes obtaining graft)	4
24152	Radical resection for tumor, radial head or neck;	3
24153	with autograft (includes obtaining graft)	4
24155	Resection of elbow joint (arthrectomy)	3
	INTRODUCTION OR REMOVAL	
24160	Implant removal; elbow joint	2
24164	radial head	3
24201	Removal of foreign body, upper arm or elbow area; deep	2
	REPAIR, REVISION AND/OR RECONSTRUCTION	
24301	Muscle or tendon transfer, any type, upper arm or elbow, single (excluding 24320 - 24331)	4
24310	Tenotomy, open, elbow to shoulder, single, each	3
24320	Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)	3
24330	Flexor-plasty, elbow, (eg, Steindler type advancement);	3
24331	with extensor advancement	3
24340	Tenodesis of biceps tendon at elbow	3
24342	Reinsertion or repair of ruptured or lacerated biceps or triceps tendon, distal, with or without tendon graft	3
24350	Fasciotomy, lateral or medial (eg, "tennis elbow" or epicondylitis);	3
24351	with extensor origin detachment	3
24352	with annular ligament resection	3
24354	with stripping	3
24356	with partial ostectomy	3
24360	Arthroplasty, elbow; with membrane	5
24361	with distal humeral prosthetic replacement	5
24362	with implant and fascia lata ligament reconstruction	5
24363	with distal humerus and proximal ulnar prosthetic replacement ("total elbow")	7
24365	Arthroplasty, radial head;	5
24366	with implant	5
24400	Osteotomy, humerus, with or without internal fixation	4
24410	Multiple osteotomies with realignment on intramedullary rod, humeral shaft (Sofield type procedure)	4
24420	Osteoplasty, humerus (eg, shortening or lengthening (excluding 64876)	3
24430	Repair of nonunion or malunion, humerus; without graft (eg, compression technique)	3
24435	with iliac or other autograft (includes obtaining graft)	4
24470	Hemiepiphyseal arrest (eg, for cubitus varus or valgus, distal humerus)	3
24495	Decompression fasciotomy, forearm, with brachial artery exploration	2
24498	Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate; humerus	3

CPT Procedure Code	Description	Group
	FRACTURE AND/OR DISLOCATION	
24500	Closed treatment of humeral shaft fracture; without manipulation	1
24505	with manipulation, with or without skeletal traction	1
24515	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage	4
24516	Open treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or looking screws	4
24530	Closed treatment of supracondylar or transcondylar humeral fracture, with or without intercondylar extension; without manipulation	1
24535	with manipulation, with or without skin or skeletal traction	1
24538	Percutaneous skeletal fixation of supracondylar or transcondylar humeral fracture, with or without intercondylar extension	2
24545	Open treatment of humeral supracondylar or transcondylar fracture, with or without internal or external fixation; without intercondylar extension	4
24546	with intercondylar extension	5
24560	Closed treatment of humeral epicondylar fracture, medial or lateral; without manipulation	1
24565	with manipulation	2
24566	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral, with manipulation	2
24575	Open treatment of humeral epicondylar fracture, medial or lateral, with or without internal or external fixation	3
24576	Closed treatment of humeral condylar fracture, medial or lateral; without manipulation	1
24577	with manipulation	1
24579	Open treatment of humeral condylar fracture, medial or lateral, with or without internal or external fixation	3
24582	Percutaneous skeletal fixation of humeral condylar fracture, medial or lateral, with manipulation	2
24586	Open treatment of periarticular fracture and/or dislocation of the elbow (fracture distal humerus and proximal ulna and/or proximal radius);	4
24587	with implant arthroplasty	5
24600	Treatment of closed elbow dislocation; without anesthesia	1
24605	requiring anesthesia	2
24615	Open treatment of acute or chronic elbow dislocation	3
24620	Closed treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with manipulation	2
24635	Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), with or without internal or external fixation	3
24655	Closed treatment of radial head or neck fracture; with manipulation	1
24665	Open treatment of radial head or neck fracture, with or without internal fixation or radial head excision;	4
24666	with radical head prosthetic replacement	4
24670	Closed treatment of ulnar fracture, proximal end (olecranon process); without manipulation	1
24675	with manipulation	1
24685	Open treatment of ulnar fracture proximal end (olecranon process), with or without internal or external fixation	3
	ARTHRODESIS	
24800	Arthrodesis, elbow joint; with or without local autograft or allograft	4
24802	with autograft (includes obtaining graft other than locally obtained)	5
	AMPUTATION	
24925	Amputation, arm through humerus; secondary closure or scar revision	3

CPT Procedure Code	Description	Group

FOREARM AND WRIST

INCISION

25000	Tendon sheath incision; at radial styloid (eg, for deQuervain's disease)	3
25020	Decompression fasciotomy, forearm and/or wrist; flexor or extensor compartment	3
25023	with debridement of nonviable muscle and/or nerve	3
25028	Incision and drainage, forearm and/or wrist; deep abscess or hematoma	1
25031	infected bursa	2
25035	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), forearm and/or wrist	2
25040	Arthrotomy, radiocarpal or midcarpal joint, with exploration, drainage, or removal of foreign body	5

EXCISION

25065	Biopsy, soft tissue of forearm and/or wrist; superficial	1
25066	deep	2
25075	Excision, tumor, forearm and/or wrist area; subcutaneous	2
25076	deep, subfascial or intramuscular	3
25077	Radical resection of tumor (eg, malignant neoplasm), soft tissue of forearm and/or wrist area	3
25085	Capsulotomy, wrist (eg, for contracture)	3
25100	Arthrotomy, wrist joint; with biopsy	2
25101	with joint exploration, with or without, biopsy, with or without removal of loose or foreign body	3
25105	with synovectomy	4
25107	Arthrotomy, distal radioulnar joint for repair of triangular cartilage complex	3
25110	Excision, lesion of tendon sheath, forearm and/or wrist	3
25111	Excision of ganglion, wrist (dorsal or volar); primary	3
25112	recurrent	4
25115	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis); flexors	4
25116	extensors with or without transposition of dorsal retinaculum	4
25118	Synovectomy, extensor tendon sheath, wrist, single compartment;	2
25119	with resection of distal ulna	3
25120	Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);	3
25125	with autograft (includes obtaining graft)	3
25126	with allograft	3
25130	Excision or curettage of bone cyst or benign tumor of carpal bones;	3
25135	with autograft (includes obtaining graft)	3
25136	with allograft	3
25145	Sequestrectomy (eg, for osteomyelitis or bone abscess); forearm and/or wrist	2
25150	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis); ulna	2
25151	radius	2
25170	Radical resection for tumor, radius or ulna	3
25210	Carpectomy; one bone	3
25215	all bones of proximal row	4
25230	Radial styloidectomy	4
25240	Excision distal ulna partial or complete (Darrach type or matched resection)	4

INTRODUCTION OR REMOVAL

25248	Exploration with removal of deep foreign body, forearm or wrist	2
25250	Removal of wrist prosthesis	1
25251	complicated, including "total wrist"	1

REPAIR, REVISION AND/OR RECONSTRUCTION

25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle	4

CPT Procedure Code	Description	Group
25263	secondary, single, each tendon or muscle	2
25265	secondary, with free graft (includes obtaining graft), each tendon or muscle	3
25270	Repair, tendon or muscle, extensor, forearm and/or wrist; primary, single, each tendon or muscle	4
25272	secondary, single, each tendon or muscle	3
25274	Repair, tendon or muscle, extensor, secondary, with tendon graft (includes obtaining graft), forearm and/or wrist, each tendon or muscle	4
25280	Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single each tendon	4
25290	Tenotomy, open, flexor or extensor tendon, forearm and/or wrist, single, each tendon	3
25295	Tenolysis, flexor or extensor tendon, forearm and/or wrist, single, each tendon	3
25300	Tenodesis at wrist; flexors of fingers	3
25301	extensors of fingers	3
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon	3
25312	with tendon graft(s) (includes obtaining graft), each tendon	4
25315	Flexor origin slide (eg, for cerebral palsy, Volkmann contracture), forearm and/or wrist;	3
25316	with tendon(s) transfer	3
25320	Capsulorrhaphy or reconstruction, wrist, any method (eg, capsulodesis, ligament repair, tendon transfer or graft) (includes synovectomy, capsulotomy and open reduction) for carpal instability	3
25332	pseudarthrosis type with internal fixation	5
25335	Centralization of wrist on ulna (eg, radial club hand)	3
25350	Osteotomy, radius; distal third	3
25355	middle or proximal third	3
25360	Osteotomy; ulna	3
25365	radius and ulna	3
25370	Multiple osteotomies, with realignment on intramedullary rod (Sofield type procedure); radius OR ulna	3
25375	radius AND ulna	4
25390	Osteoplasty, radius OR ulna; shortening	3
25391	lengthening with autograft	4
25392	Osteoplasty, radius AND ulna; shortening (excluding 64876)	3
25393	lengthening with autograft	4
25400	Repair of nonunion or malunion, radius OR ulna; without graft (eg, compression technique)	3
25405	with iliac or other autograft (includes obtaining graft)	4
25415	Repair of nonunion or malunion, radius AND ulna; without graft (eg, compression technique)	3
25420	with iliac or other autograft (includes obtaining graft)	4
25425	Repair of defect with autograft; radius OR ulna	3
25426	radius AND ulna	4
25440	Repair of nonunion, scaphoid (navicular) bone, with or without radial styloidectomy (includes obtaining graft and necessary fixation)	4
25441	Arthroplasty with prosthetic replacement; distal radius	5
25442	distal ulna	5
25443	scaphoid (navicular)	5
25444	lunate	5
25445	trapezium	5
25446	distal radius and partial or entire carpus ("total wrist")	7
25447	Interposition arthroplasty, intercarpal or carpometacarpal joints	5
25449	Revision of arthroplasty, including removal of implant, wrist joint	5
25450	Epiphyseal arrest by epiphysiodesis or stapling; distal radius OR ulna	3
25455	distal radius AND ulna	3

CPT Procedure Code	Description	Group
25490	Prophylactic treatment (nailing, pinning, plating or wiring), with or without methylmethacrylate; radius	3
25491	ulna	3
25492	radius AND ulna	3
	FRACTURE AND/OR DISLOCATION	
25505	Closed treatment of radial shaft fracture; with manipulation	1
25515	Open treatment of radial shaft fracture, with or without internal or external fixation	3
25520	Closed treatment of radial shaft fracture, with dislocation of distal radio-ulnar joint (Galeazzi fracture/dislocation)	1
25525	Open treatment of radial shaft fracture, with internal and/or external fixation and closed treatment of dislocation of distal radio-ulnar joint (Galeazzi fracture/dislocation), with or without percutaneous skeletal fixation	4
25526	Open treatment of radial shaft fracture, with internal and/or external fixation and open treatment, with or without internal or external fixation of distal radio-ulnar joint (Galeazzi fracture/dislocation), includes repair of triangular cartilage	5
25535	Closed treatment of ulnar shaft fracture; with manipulation	1
25545	Open treatment of ulnar shaft fracture, with or without internal or external fixation	3
25565	Closed treatment of radial and ulnar shaft fractures; with manipulation	2
25574	Open treatment of radial AND ulnar shaft fractures, with internal or external fixation; of radius or ulna	3
25575	of radius AND ulna	3
25605	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; with manipulation	3
25611	Percutaneous skeletal fixation of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, requiring manipulation, with or without external fixation	3
25620	Open treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid, with or without internal or external fixation	5
25624	Closed treatment of carpal scaphoid (navicular) fracture; with manipulation	2
25628	Open treatment of carpal scaphoid (navicular) fracture, with or without internal or external fixation	3
25635	Closed treatment of carpal bone fracture (excluding carpal scaphoid (navicular)); with manipulation, each bone	1
25645	Open treatment of carpal bone fracture (excluding carpal scaphoid (navicular)), each bone	3
25660	Closed treatment of radiocarpal or intercarpal dislocation, one or more bones, with manipulation	1
25670	Open treatment of radiocarpal or intercarpal dislocation, one or more bones	3
25675	Closed treatment of distal radioulnar dislocation with manipulation	1
25676	Open treatment of distal radioulnar dislocation, acute or chronic	2
25680	Closed treatment of trans-scaphoperilunar type of fracture dislocation, with manipulation	2
25685	Open treatment of trans-scaphoperilunar type of fracture dislocation	3
25690	Closed treatment of lunate dislocation, with manipulation	1
25695	Open treatment of lunate dislocation	2
	ARTHRODESIS	
25800	Arthrodesis, wrist joint (including radiocarpal and/or ulnocarpal fusion); without bone graft	4
25805	with sliding graft	5
25810	with iliac or other autograft (includes obtaining graft)	5
25820	Intercarpal fusion; without bone graft	4
25825	with autograft (includes obtaining graft)	5

CPT Procedure Code	Description	Group
	AMPUTATION	
25907	Amputation, forearm, through radius and ulna; secondary closure or scar revision	3
25922	Disarticulation through wrist; secondary closure or scar revision	3
25929	Transmetacarpal amputation; secondary closure or scar revision	3

HANDS AND FINGERS

INCISION

26011	Drainage of finger abscess; complicated (eg, felon)	1
26020	Drainage of tendon sheath, one digit and/or palm	2
26025	Drainage of palmar bursa; single, ulnar or radial	1
26030	multiple or complicated	2
26034	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), hand or finger	2
26035	Decompression fingers and/or hand, injection injury (eg, grease gun)	4
26037	Decompression fasciotomy, hand (excludes 26035)	4
26040	Fasciotomy, palmar, for Dupuytren's contracture; closed (subcutaneous)	4
26045	open, partial	3
26055	Tendon sheath incision (eg, for trigger finger)	2
26060	Tenotomy, subcutaneous, single, each digit	2
26070	Arthrotomy, for infection, with exploration, drainage or removal of foreign body; carpometacarpal joint	2
26075	metarcarpophlangeal joint	4
26080	interphalangeal joint, each	4

EXCISION

26100	Arthrotomy for synovial biopsy; carpometacarpal joint	2
26105	metacarpophalangeal joint	1
26110	interphalangeal joint, each	1
26115	Excision, tumor or vascular malformation, hand or finger; subcutaneous	2
26116	deep, subfascial, intramuscular	2
26117	Radical resection of tumor (eg, malignant neoplasm), soft tissue of hand or finger	3
26121	Fasciectomy, palmar only, with or without z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)	4
26123	partial palmar excision with release of single digit including proximal interphalangeal joint	4
26125	partial excision with release of each additional digit, including proximal interphalangeal joint	4
26130	Synovectomy, carpometacarpal joint	3
26135	Synovectomy, metacarpophalangeal joint including intrinsic release and extensor hood reconstruction, each digit	4
26140	Synovectomy, proximal interphalangeal joint, including extensor reconstruction, each interphalangeal joint	2
26145	Synovectomy tendon sheath, radical (tenosynovectomy), flexor, palm or finger, single, each digit	3
26160	Excision of lesion of tendon sheath or capsule (eg, cyst, mucous cyst, or ganglion), hand or finger	3
26170	Excision of tendon, palm, flexor, single, each	3
26180	Excision of tendon, finger, flexor	3
26200	Excision or curettage of bone cyst or benign tumor of metacarpal;	2
26205	with autogenous graft (includes obtaining graft)	3
26210	Excision or curettage of bone cyst or benign tumor of proximal, middle or distal phalanx of finger;	2
26215	with autograft (includes obtaining graft)	3
26230	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis); metacarpal	7
26235	proximal or middle phalanx of finger	3
26236	distal phalanx of finger	3

CPT Procedure Code	Description	Group
26250	Radical resection (ostectomy) for tumor, metacarpal;	3
26255	with autograft (includes obtaining graft)	3
26260	Radical resection (ostectomy) for tumor, proximal or middle phalanx of finger;	3
26261	with autograft (includes obtaining graft)	3
26262	Radical resection (ostectomy) for tumor, distal phalanx of finger	2
	INTRODUCTION OR REMOVAL	
26320	Removal of implant from finger or hand	2
	REPAIR, REVISION AND/OR RECONSTRUCTION	
26350	Flexor tendon repair or advancement, single, not in "no man's land"; primary or secondary without free graft, each tendon	1
26352	secondary with free graft (includes obtaining graft), each tendon	4
26356	Flexor tendon repair or advancement, single, in "no man's land"; primary, each tendon	4
26357	secondary, each tendon	4
26358	secondary with free graft (includes obtaining graft), each tendon	4
26370	Profundus tendon repair or advancement, with intact sublimis; primary	4
26372	secondary with free graft (includes obtaining graft)	4
26373	secondary without free graft	3
26390	Flexor tendon excision, implantation of plastic tube or rod for delayed tendon graft, hand or finger	4
26392	Removal of tube or rod and insertion of flexor tendon graft (includes obtaining graft), hand or finger	3
26410	Extensor tendon repair, dorsum of hand, single, primary or secondary; without free graft, each tendon	3
26412	with free graft (includes obtaining graft), each tendon	3
26415	Extensor tendon excision, implantation of plastic tube or rod for delayed extensor tendon graft, hand or finger	4
26416	Removal of tube or rod and insertion of extensor tendon graft (includes obtaining graft), hand or finger	3
26418	Extensor tendon repair, dorsum of finger, single, primary or secondary; without free graft, each tendon	4
26420	with free graft (includes obtaining graft), each tendon	4
26426	Extensor tendon repair, central slip repair, secondary (boutonniere deformity); using local tissues	3
26428	with free graft (includes obtaining graft)	3
26432	Extensor tendon repair, distal insertion ("mallet finger"), closed, splinting with or without percutaneous pinning	3
26433	Extensor tendon repair, distal insertion ("mallet finger"), open, primary or secondary repair; without graft	3
26434	with free graft (includes obtaining graft)	3
26437	Extensor tendon realignment, hand	3
26440	Tenolysis, simple, flexor tendon; palm OR finger, single, each tendon	3
26442	palm AND finger, each tendon	3
26445	Tenolysis, extensor tendon, dorsum of hand or finger; each tendon	3
26449	Tenolysis, complex, extensor tendon, dorsum of hand or finger, including hand and forearm	3
26450	Tenotomy, flexor, single, palm, open, each	3
26455	Tenotomy, flexor, single, finger, open, each	3
26460	Tenotomy, extensor, hand or finger, single, open, each	3
26471	Tenodesis; for proximal interphalangeal joint stabilization	2
26474	for distal joint stabilization	2
26476	Tendon lengthening, extensor, hand or finger, single, each	1
26477	Tendon shortening, extensor, hand or finger single, each	1
26478	Tendon lengthening, flexor, hand or finger, single, each	1

CPT Procedure Code	Description	Group
26479	Tendon shortening, flexor, hand or finger, single, each	1
26480	Tendon transfer or transplant, carpometa-carpal area or dorsum of hand, single; without free graft, each	3
26483	with free tendon graft (includes obtaining graft), each tendon	3
26485	Tendon transfer or transplant, palmar, single, each tendon; without free tendon graft	2
26489	with free tendon graft (includes obtaining graft), each tendon	3
26490	Opponensplasty; sublimis tendon transfer type	3
26492	tendon transfer with graft (includes obtaining graft)	3
26494	hypothenar muscle transfer	3
26496	other methods	3
26497	Tendon transfer to restore intrinsic function; ring and small finger	3
26498	all four fingers	4
26499	Correction claw finger, other methods	3
26500	Tendon pulley reconstruction; with local tissues	4
26502	with tendon or fascial graft (includes obtaining graft)	4
26504	with tendon prosthesis	4
26508	Thenar muscle release for thumb contracture	3
26510	Cross intrinsic transfer	3
26516	Capsulodesis for M-P joint stabilization; single digit	1
26517	two digits	3
26518	three or four digits	3
26520	Capsulectomy or capsolotomy for contracture; metacarpophalangeal joint, single, each	3
26525	interphalangeal joint, single, each	3
26530	Arthroplasty, metacarpophalangeal joint; single, each	3
26531	with prosthetic implant, single, each	7
26535	Arthroplasty interphalangeal joint; single, each	5
26536	with prosthetic implant, single, each	5
26540	Primary repair of collateral ligament, metacarpophalangeal joint;	4
26541	with tendon or fascial graft (includes obtaining graft)	7
26542	with local tissue (eg, adductor advancement)	4
26545	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint	4
26548	Repair and reconstruction, finger, volar plate, interphalangeal joint	4
26550	Pollicization of a digit	2
26551	Toe-to-hand transfer with microvascular anastomosis; great toe “wrap-around” with bone graft	4
26553	other than great toe, single	2
26554	other than great toe, double	2
26555	Positional change of other finger	3
26560	Repair of syndactyly (web finger) each web space; with skin flaps	2
26561	with skin flaps and grafts	3
26562	complex (eg, involving bone, nails)	4
26565	Osteotomy for correction of deformity; metacarpal	5
26567	phalanx of finger	5
26568	Osteoplasty for lengthening of metacarpal or phalanx	3
26580	Repair cleft hand	5
26585	Repair bifid digit	5
26587	Reconstruction of supernumerary digit, soft tissue and bone	5
26590	Repair macrodactylia	5
26591	Repair, intrinsic muscles of hand (specify)	3
26593	Release, intrinsic muscles of hand (specify)	3
26596	Excision of constricting ring of finger, with multiple Z-plasties	2
26597	Release of scar contracture, flexor or extensor, with skin grafts, rearrangement flaps, or Z-plasties, hand and/or finger	3

CPT Procedure Code	Description	Group
	FRACTURES AND/OR DISLOCATIONS	
26605	Closed treatment of metacarpal fracture, single; with manipulation, each bone	2
26607	Closed treatment of metacarpal fracture, with manipulation, with internal or external fixation, each bone	2
26615	Open treatment of metacarpal fracture, single, with or without internal or external fixation, each bone	4
26645	Closed treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation	1
26650	Percutaneous skeletal fixation of carpometacarpal fracture dislocation, thumb (Bennett fracture), with manipulation, with or without external fixation	2
26665	Open treatment of carpometacarpal fracture dislocation, thumb (Bennett fracture), with or without internal or external fixation	4
26675	Closed treatment of carpometacarpal dislocation, other than thumb (Bennett fracture), single, with manipulation; requiring anesthesia	2
26676	Percutaneous skeletal fixation of carpometacarpal dislocation, other than thumb (Bennett fracture), single, with manipulation	2
26685	Open treatment of carpometacarpal dislocation, other than thumb (Bennett fracture); single, with or without internal or external fixation	3
26686	complex, multiple or delayed reduction	3
26705	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia	2
26706	Percutaneous skeletal fixation of metacarpophalangeal dislocation, single, with manipulation	2
26715	Open treatment of metacarpophalangeal dislocation, single, with or without internal or external fixation	4
26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each	7
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with or without internal or external fixation, each	4
26742	Closed treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint; with manipulation, each	2
26746	Open treatment of articular fracture, involving metacarpophalangeal or interphalangeal joint, with or without internal or external fixation, each	5
26756	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each	2
26765	Open treatment of distal phalangeal fracture, finger or thumb, with or without internal or external fixation, each	4
26775	Closed treatment of interphalangeal joint dislocation, single, with manipulation; requiring anesthesia	2
26776	Percutaneous skeletal fixation of interphalangeal joint dislocation, single, with manipulation	2
26785	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation, single	2
	ARTHRODESIS	
26820	Fusion in opposition, thumb, with autogenous graft (includes obtaining graft)	5
26841	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation;	4
26842	with autograft (includes obtaining graft)	4
26843	Arthrodesis, carpometacarpal joint, digits, other than thumb;	3
26844	with autograft (includes obtaining graft)	3
26850	Arthrodesis, metacarpophalangeal joint, with or without internal fixation;	4
26852	with autograft (includes obtaining graft)	4
26860	Arthrodesis, interphalangeal joint, with or without internal fixation;	3
26861	each additional interphalangeal joint	2
26862	with autograft (includes obtaining graft)	4
26863	with autograft (includes obtaining graft), each additional joint	3

CPT Procedure Code	Description	Group
	AMPUTATION	
26910	Amputation, metacarpal, with finger or thumb (ray amputation), single, with or without interosseous transfer	3
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	2
26952	with local advancement flaps (V-Y, hood)	4

PELVIS AND HIP JOINT

	INCISION	
26990	Incision and drainage, pelvis or hip joint area; deep abscess or hematoma	1
26991	infected bursa	1
26992	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), pelvis and/or hip joint	2
27000	Tenotomy, adductor of hip, subcutaneous, closed	2
27001	Tenotomy, adductor of hip, subcutaneous, open	3
27003	Tenotomy, adductor, subcutaneous, open, with obturator neurectomy	3
27030	Arthrotomy, hip, for infection, with drainage	3
27033	Arthrotomy, hip, with exploration or removal of loose or foreign body	3
27035	Hip joint denervation, intrapelvic or extrapelvic intra-articular branches of sciatic, femoral or obturator nerves	4
	EXCISION	
27040	Biopsy, soft tissue of pelvis and hip area; superficial	1
27041	deep	2
27047	Excision, tumor, pelvis and hip area; subcutaneous	2
27048	deep, subfascial, intramuscular	3
27049	Radical resection of tumor (eg, malignant neoplasm), soft tissue of pelvis and hip area	3
27050	Arthrotomy, with biopsy; sacroiliac joint	3
27052	hip joint	3
27060	Excision; ischial bursa	5
27062	trochanteric bursa or calcification	5
27065	Excision of bone cyst or benign tumor; superficial (wing of ilium, symphysis pubis, or greater trochanter of femur) with or without autograft	5
27066	deep, with or without autograft	5
27080	Coccygectomy, primary	2
	INTRODUCTION AND/OR REMOVAL	
27086	Removal of foreign body, pelvis or hip; subcutaneous tissue	1
27087	deep	3
	REPAIR, REVISION, AND/OR RECONSTRUCTION	
27097	Hamstring recession, proximal	3
27098	Adductor transfer to ischium	3
27100	Transfer external oblique muscle to greater trochanter including fascial or tendon extension (graft)	4
27105	Transfer paraspinal muscle to hip (includes fascial or tendon extension graft)	4
27110	Transfer iliopsoas; to greater trochanter	4
27111	to femoral neck	4
	FRACTURES AND/OR DISLOCATIONS	
27193	Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation	1
27194	with manipulation, requiring more than local anesthesia	2
27202	Open treatment of coccygeal fracture	2
27230	Closed treatment of femoral fracture, proximal end, neck; without manipulation	1
27238	Closed treatment of intertrochanteric, pertrochanteric, or subtrochanteric femoral fracture; without manipulation	1
27246	Closed treatment of greater trochanteric fracture, without manipulation	1

CPT Procedure Code	Description	Group
27250	Closed treatment of hip dislocation, traumatic; without anesthesia	1
27252	requiring anesthesia	2
27265	Closed treatment of post hip arthroplasty dislocation; without anesthesia	1
27266	requiring regional or general anesthesia	2
	MANIPULATION	
27275	Manipulation, hip joint, requiring general anesthesia	2

FEMUR (THIGH REGION) AND KNEE JOINT

	INCISION	
27301	Incision and drainage of deep abscess, infected bursa, or hematoma, thigh or knee region	3
27303	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), femur or knee	2
27305	Fasciotomy, iliotibial (tenotomy), open	2
27306	Tenotomy, subcutaneous, closed, adductor or hamstring; single	3
27307	multiple	3
27310	Arthrotomy, knee, for infection, with exploration, drainage or removal of foreign body	4
27315	Neurectomy, hamstring muscle	2
27320	Neurectomy, popliteal (gastrocnemius)	2
	EXCISION	
27323	Biopsy, soft tissue of thigh or knee area; superficial	1
27324	deep	1
27327	Excision, tumor, thigh or knee area; subcutaneous	2
27328	deep, subfascial, or intramuscular	3
27330	Arthrotomy, knee; with synovial biopsy only	4
27331	with joint exploration, with or without biopsy, with or without removal of loose or foreign bodies	4
27332	Arthrotomy, knee, with excision of semilunar cartilage (meniscectomy); medial OR lateral	4
27333	medial AND lateral	4
27334	Arthrotomy, knee, with synovectomy; anterior OR posterior	4
27335	anterior AND posterior including popliteal area	4
27340	Excision, prepatellar bursa	3
27345	Excision of synovial cyst of popliteal space (Baker's cyst)	4
27350	Patellectomy or hemipatellectomy	4
27355	Excision or curettage of bone cyst or benign tumor of femur;	3
27356	with allograft	4
27360	Partial excision (craterization, saucerization or diaphysectomy) of bone (eg, for osteomyelitis), femur, proximal tibia and/or fibula	5
	REMOVAL	
27372	Removal of foreign body, deep, thigh region or knee area	7
	REPAIR, REVISION, AND/OR RECONSTRUCTION	
27380	Suture of infrapatellar tendon; primary	1
27381	secondary reconstruction, including fascial or tendon graft	3
27385	Suture of quadriceps or hamstring muscle rupture; primary	3
27386	secondary reconstruction, including fascial or tendon graft	3
27390	Tenotomy, open, hamstring, knee to hip; single	1
27391	multiple, one leg	2
27392	multiple, bilateral	3
27393	Lengthening of hamstring tendon; single	2
27394	multiple, one leg	3
27395	multiple, bilateral	3
27396	Transplant, hamstring tendon to patella; single	3
27397	multiple	3
27400	Tendon or muscle transfer, hamstrings to femur (Eggers type procedure)	3

CPT Procedure Code	Description	Group
27403	Arthrotomy with open meniscus repair	4
27405	Repair, primary, torn ligament and/or capsule, knee; collateral	4
27407	cruciate	4
27409	collateral and cruciate ligaments	4
27418	Anterior tibial tubercleplasty (eg, for chondromalacia patellae)	3
27420	Reconstruction for recurrent dislocating patella; (Hauser type procedure)	3
27422	with extensor realignment and/or muscle advancement or release (Campbell, Goldwaite type procedure)	7
27424	with patellectomy	3
27425	Lateral retinacular release (any method)	7
27427	Ligamentous reconstruction (augmentation), knee; extra-articular	3
27428	intra-articular (open)	4
27429	intra-articular (open) and extra-articular	4
27430	Quadricepsplasty (Bennett or Thompson type)	4
27435	Capsulotomy, knee, posterior capsular release	4
27437	Arthroplasty, patella; without prosthesis	4
27438	with prosthesis	5
27440	Arthroplasty, knee, tibial plateau;	5
27441	with debridement and partial synovectomy	5
27442	Arthroplasty, knee, femoral condyles or tibial plateaus;	5
27443	with debridement and partial synovectomy	5

FRACTURE AND/OR DISLOCATION

CPT Procedure Code	Description	Group
27500	Closed treatment of femoral shaft fracture, without manipulation	1
27501	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation	2
27502	Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction	2
27503	Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction	3
27507	Open treatment of femoral shaft fracture with plate/screws, with or without cerclage	4
27508	Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation	1
27509	Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphyseal separation	3
27510	Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation	1
27511	Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, with or without internal or external fixation	4
27513	Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, with or without internal or external fixation	5
27516	Closed treatment of distal femoral epiphyseal separation; without manipulation	1
27517	with manipulation, with or without skin or skeletal traction	1
27520	Closed treatment of patellar fracture, without manipulation	1
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair	3
27530	Closed treatment of tibial fracture, proximal (plateau); without manipulation	1
27532	with or without manipulation, with skeletal traction	1
27535	Open treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation	3
27538	Closed treatment of intercondylar spine(s) and/or tuberosity fracture(s) of knee, with or without manipulation	1
27550	Closed treatment of knee dislocation; without anesthesia	1

CPT Procedure Code	Description	Group
27552	requiring anesthesia	1
27560	Closed treatment of patellar dislocation; without anesthesia	1
27562	requiring anesthesia	1
27566	Open treatment of patellar dislocation, with or without partial or total patellectomy	2

MANIPULATION

27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)	1

LEG (TIBIA AND FIBULA) AND ANKLE JOINT

INCISION

27603	Incision and drainage, leg or ankle; deep abscess or hematoma	2
27604	infected bursa	2
27605	Tenotomy, Achilles tendon, subcutaneous, local anesthesia	1
27606	general anesthesia	1
27607	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), leg or ankle	2
27610	Arthrotomy, ankle, for infection, with exploration, drainage or removal of foreign body	2
27612	Arthrotomy, ankle, posterior capsular release, with or without Achilles tendon lengthening	3

EXCISION

27613	Biopsy, soft tissue of leg or ankle area; superficial	1
27614	deep	2
27615	Radical resection of tumor (eg, malignant neoplasm), soft tissue of leg or ankle area	3
27618	Excision, tumor, leg or ankle area; subcutaneous	2
27619	deep, subfascial or intramuscular	3
27620	Arthrotomy, ankle, with joint exploration, with or without biopsy, with or without removal of loose or foreign body	4
27625	Arthrotomy, ankle, with synovectomy;	4
27626	including tenosynovectomy	4
27630	Excision of lesion of tendon sheath or capsule (eg, cyst or ganglion), leg and/or ankle	3
27635	Excision of curettage of bone cyst or benign tumor, tibia or fibula;	3
27637	with autograft (includes obtaining graft)	3
27638	with allograft	3
27640	Partial excision (craterization, saucerization, or diaphysectomy) of bone, (eg, for osteomyelitis exostosis); tibia	2
27641	fibula	2

REPAIR, REVISION OR RECONSTRUCTION

27650	Repair, primary, open or percutaneous, ruptured Achilles tendon;	3
27652	with graft (includes obtaining graft)	3
27654	Repair, secondary, ruptured Achilles tendon, with or without graft	3
27656	Repair, fascial defect of leg	2
27658	Repair or suture of flexor tendon of leg; primary, without graft, single, each	1
27659	secondary, with or without graft, single tendon, each	2
27664	Repair or suture of extensor tendon of leg; primary, without graft, single, each	2
27665	secondary with or without graft, single tendon, each	2
27675	Repair for dislocating peroneal tendons; without fibular osteotomy	2
27676	with fibular osteotomy	3
27680	Tenolysis, including tibia, fibula and ankle flexor; single	3
27681	multiple (through same incision), each	2
27685	Lengthening or shortening of tendon, leg or ankle; single	3
27686	multiple (through same incision), each	3

CPT Procedure Code	Description	Group
27687	Gastrocnemius recession (eg, Strayer procedure)	3
27690	Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)	4
27691	anterior tibial or posterior tibial through interosseous space	4
27692	each additional tendon	3
27695	Suture, primary, torn, ruptured or severed ligament, ankle; collateral	2
27696	both collateral ligaments	2
27698	Suture, secondary repair, torn, ruptured or severed ligament, ankle, collateral (eg, Watson-Jones procedure)	2
27700	Arthroplasty, ankle	5
27704	Removal of ankle implant	2
27705	Osteotomy; tibia	2
27707	fibula	2
27709	tibia and fibula	2
27715	Osteoplasty, tibia and fibula, lengthening	4
27730	Epiphyseal arrest by epiphysiodesis or stapling; distal tibia	2
27732	distal fibula	2
27734	distal tibia and fibula	2
27740	Epiphyseal arrest by epiphysiodesis or stapling, combined, proximal and distal tibia and fibula;	2
27742	and distal femur	2
27745	Prophylactic treatment (nailing, pinning, plating or wiring) with or without methylmethacrylate, tibia	3

FRACTURE AND/OR DISLOCATION

CPT Procedure Code	Description	Group
27750	Closed treatment of tibial shaft fracture (with or without fibular fracture); without manipulation	1
27752	with manipulation, with or without skeletal traction	1
27756	Percutaneous skeletal fixation of tibial shaft fracture (with or without fibular fracture) (eg, pins or screws)	3
27758	Open treatment of tibial shaft fracture, (with or without fibular fracture) with plates/screws, with or without cerclage	4
27759	Open treatment of tibial shaft fracture (with or without fibula fracture) by intramedullary implant, with or without interlocking screws and/or cerclage	4
27760	Closed treatment of medial malleolus fracture; without manipulation	1
27762	with manipulation, with or without skin or skeletal traction	1
27766	Open treatment of medial malleolus fracture, with or without internal or external fixation	3
27780	Closed treatment of proximal fibula or shaft fracture; without manipulation	1
27781	with manipulation	1
27784	Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation	3
27786	Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	1
27788	with manipulation	1
27792	Open treatment of distal fibular fracture (lateral malleolus), with or without internal or external fixation	3
27808	Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation	1
27810	with manipulation	1
27814	Open treatment of bimalleolar ankle fracture, with or without internal or external fixation	3
27816	Closed treatment of trimalleolar ankle fracture; without manipulation	1
27818	with manipulation	1
27822	Open treatment of trimalleolar ankle fracture, with or without internal or external fixation, medial and/or lateral malleolus; without fixation of posterior lip	3
27823	with fixation of posterior lip	3
27824	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; without manipulation	1

CPT Procedure Code	Description	Group
27825	with skeletal traction and/or requiring manipulation	2
27826	Open treatment of fracture of weight bearing articular surface/portion of distal tibia (eg, pilon or tibial plafond), internal or external fixation; of fibula only	3
27827	of tibia only	3
27828	of both tibia and fibula	4
27829	Open treatment of distal tibiofibular joint (syndesmosis) disruption, with or without internal or external fixation	2
27830	Closed treatment of proximal tibiofibular joint dislocation; without anesthesia	1
27831	requiring anesthesia	1
27832	Open treatment of proximal tibiofibular joint dislocation, with or without internal or external fixation, or with excision of proximal fibula	2
27840	Closed treatment of ankle dislocation; without anesthesia	1
27842	requiring anesthesia, with or without percutaneous skeletal fixation	1
27846	Open treatment of ankle dislocation, with or without percutaneous skeletal fixation; without repair or internal fixation	3
27848	with repair or internal or external fixation	3
MANIPULATION		
27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)	1
ARTHRODESIS		
27870	Arthrodesis, ankle, any method	4
27871	Arthrodesis, tibiofibular joint, proximal or distal	4
AMPUTATION		
27884	Amputation, leg, through tibia and fibula; secondary closure or scar revision	3

CPT Procedure Code	Description	Group
FOOT AND TOES		
INCISION		
28002	Deep dissection below fascia, for deep infection of foot, with or without tendon sheath involvement; single bursal space, specify	3
28003	multiple areas	3
28005	Incision, deep, with opening of bone cortex (eg, for osteomyelitis or bone abscess), foot	3
28008	Fasciotomy, foot and/or toe	3
28020	Arthrotomy, with exploration, drainage or removal of loose or foreign body; intertarsal or tarsometatarsal joint	2
28030	Neurectomy of intrinsic musculature of foot	4
28035	Tarsal tunnel release (posterior tibial nerve decompression)	4
EXCISION		
28043	Excision, tumor, foot; subcutaneous	2
28045	deep, subfascial, intramuscular	3
28046	Radical resection of tumor (eg, malignant neoplasm), soft tissue of foot	3
28050	Arthrotomy for synovial biopsy; intertarsal or tarsometatarsal joint	2
28054	interphalangeal joint	2
28060	Fasciectomy, excision of plantar fascia; partial	2
28062	radical	3
28070	Synovectomy; intertarsal or tarsometatarsal joint, each	3
28072	metatarsophalangeal joint, each	3
28080	Excision of interdigital (Morton) neuroma, single, each	3
28086	Synovectomy, tendon sheath, foot; flexor	2
28088	extensor	2
28090	Excision of lesion of tendon or fibrous sheath or capsule (including synovectomy) (cyst or ganglion); foot	3
28092	toes	3

CPT Procedure Code	Description	Group
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus;	2
28102	with iliac or other autograft (includes obtaining graft)	3
28103	with allograft	3
28104	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal bones, except talus or calcaneus	2
28106	with iliac or other autograft (includes obtaining graft)	3
28107	with allograft	3
28108	Excision or curettage of bone cyst or benign tumor, phalanges of foot	3
28110	Ostectomy, partial excision, fifth metatarsal head (bunionette)	3
28111	Ostectomy, complete excision; first metatarsal head	3
28112	other metatarsal head (second, third or fourth)	3
28113	fifth metatarsal head	3
28114	all metatarsal heads, with partial proximal phalangectomy, excluding first metatarsal (Clayton type procedure)	3
28116	Ostectomy, excision of tarsal coalition	3
28118	Ostectomy, calcaneus;	4
28119	for spur, with or without plantar fascial release	4
28120	Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) of bone (eg, for osteomyelitis or talar bossing), talus or calcaneus	7
28122	Partial excision (craterization, saucerization, or diaphysectomy) of bone (eg, for osteomyelitis or talar bossing), tarsal or metatarsal bone, except talus or calcaneus	3
28130	Talectomy (astragalectomy)	3
28140	Metatarsectomy	3
28150	Phalangectomy of toe, single, each	3
28153	Resection, head of phalanx, toe	3
28171	Radical resection of tumor, bone; tarsal (except talus or calcaneus)	3
28173	metatarsal	3
28175	phalanx of toe	3

CPT Procedure Code	Description	Group
	INTRODUCTION OR REMOVAL	
28192	Removal of foreign body, foot; deep	2
28193	complicated	4
	REPAIR, REVISION AND/OR RECONSTRUCTION	
28200	Repair or suture of tendon, foot, flexor, single; primary or secondary, without free graft, each tendon	3
28202	secondary with free graft, each tendon (includes obtaining graft)	3
28208	Repair or suture of tendon, foot, extensor, single; primary or secondary, each tendon	3
28210	secondary with free graft, each tendon (includes obtaining graft)	3
28220	Tenolysis, flexor, foot; single tendon	1
28222	multiple tendons	1
28225	Tenolysis, extensor, foot; single	1
28226	multiple (through same incision)	1
28234	Tenotomy, open, extensor, foot or toe	2
28238	Advancement of posterior tibial tendon with excision of accessory navicular bone (Kidner type procedure)	3
28240	Tenotomy, lengthening, or release, abductor hallucis muscle	2
28250	Division of plantar fascia and muscle ("Steindler stripping")	3
28260	Capsulotomy, midfoot; medial release only	3
28261	with tendon lengthening	3
28262	extensive, including posterior talotibial capsulotomy and tendon(s) lengthening as for resistant clubfoot deformity	4
28264	Capsulotomy, midtarsal (Heyman type procedure)	1
28270	Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint	1
28280	Webbing operation (create syndactylism of toes) (Kelikian type procedure)	2
28285	Hammertoe operation, one toe (eg, inter-phalangeal fusion, filleting, phalangectomy)	3

CPT Procedure Code	Description	Group
28286	Cock-up fifth toe operation with plastic skin closure (Ruiz-Mora type procedure)	4
28288	Ostectomy, partial, exostectomy or condylectomy, single, metatarsal head, first through fifth, each metatarsal head	3
28290	Hallux valgus (bunion) correction, with or without sesamoidectomy; simple exostectomy (Silver type procedure)	2
28292	Keller, McBride or Mayo type procedure	2
28293	resection of joint with implant	3
28294	with tendon transplants (Joplin type procedure)	3
28296	with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)	3
28297	Lapidus type procedure	3
28298	by phalanx osteotomy	3
28299	by other methods (eg, double osteotomy)	5
28300	Osteotomy; calcaneus (Dwyer or Chambers type procedure), with or without internal fixation	2
28302	talus	2
28304	Osteotomy, midtarsal bones, other than calcaneus or talus;	2
28305	with autograft (includes obtaining graft) (Fowler type)	3
28306	Osteotomy, metatarsal, base or shaft, single, with or without lengthening, for shortening or angular correction; first metatarsal	4
28307	first metatarsal with autograft	4
28308	other than first metatarsal	2
28309	Osteotomy, metatarsals, multiple, for cavus foot (Swanson type procedure)	4
28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe	3
28312	other phalanges, any toe	3
28313	Reconstruction, angular deformity of toe (overlapping second toe, fifth toe, curly toes), soft tissue procedures only	2
28315	Sesamoidectomy, first toe	4
28320	Repair of nonunion or malunion; tarsal bones (eg, calcaneus, talus)	4
28322	metatarsal, with or without bone graft (includes obtaining graft)	4
28340	Reconstruction, toe, macrodactyly; soft tissue resection	4
28341	requiring bone resection	4
28344	Reconstruction, toe(s); polydactyly	4
28345	syndactyly, with or without skin graft(s), each web	4

FRACTURE AND/OR DISLOCATION

28400	Closed treatment of calcaneal fracture; without manipulation	1
28405	with manipulation	2
28406	Percutaneous skeletal fixation of calcaneal fracture, with manipulation	2
28415	Open treatment of calcaneal fracture, with or without internal or external fixation;	3
28420	with primary iliac or other autogenous bone graft (includes obtaining graft)	4
28435	Closed treatment of talus fracture; with manipulation	2
28436	Percutaneous skeletal fixation of talus fracture, with manipulation	2
28445	Open treatment of talus fracture, with or without internal or external fixation	3
28456	Percutaneous skeletal fixation of tarsal bone fracture (except talus and calcaneus), with manipulation, each	2
28465	Open treatment of tarsal bone fracture (except talus and calcaneus), with or without internal or external fixation, each	3
28476	Percutaneous skeletal fixation of metatarsal fracture, with manipulation, each	2
28485	Open treatment of metatarsal fracture, with or without internal or external fixation, each	4
28496	Percutaneous skeletal fixation of fracture great toe, phalanx or phalanges, with manipulation	2
28505	Open treatment of fracture great toe, phalanx or phalanges, with or without internal or external fixation	3
28525	Open treatment of fracture, phalanx or phalanges, other than great toe, with or without internal or external fixation, each	3

CPT Procedure Code	Description	Group
28545	Closed treatment of tarsal bone dislocation, other than talotarsal; requiring anesthesia	1
28546	Percutaneous skeletal fixation of tarsal bone dislocation, other than talotarsal, with manipulation\	2
28555	Open treatment of tarsal bone dislocation, with or without internal or external fixation	2
28575	Closed treatment of talotarsal joint dislocation; requiring anesthesia	1
28576	Percutaneous skeletal fixation of talotarsal joint dislocation, with manipulation	3
28585	Open treatment of talotarsal joint dislocation, with or without internal or external fixation	3
28605	Closed treatment of tarsometatarsal joint dislocation; requiring anesthesia	1
28606	Percutaneous skeletal fixation of tarsometatarsal joint dislocation, with manipulation	2
28615	Open treatment of tarsometatarsal joint dislocation, with or without internal or external fixation	3
28635	Closed treatment of metatarsophalangeal joint dislocation; requiring anesthesia	1
28636	Percutaneous skeletal fixation of metatarsophalangeal joint dislocation, with manipulation	3
28645	Open treatment of metatarsophalangeal joint dislocation, with or without internal or external fixation	3
28665	Closed treatment of interphalangeal joint dislocation; requiring anesthesia	1
28666	Percutaneous skeletal fixation of interphalangeal joint dislocation, with manipulation	3
28675	Open treatment of interphalangeal joint dislocation, with or without internal or external fixation	3
ARTHRODESIS		
28705	Pantalar arthodesis	4
28715	Triple arthrodesis	4
28725	Subtalar arthrodesis	4
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;	4
28735	with osteotomy as for flatfoot correction	4
28737	Arthrodesis, midtarsal navicular-cuneiform, with tendon lengthening and advancement (Miller type procedure)	5
28740	Arthrodesis, midtarsal or tarsometatarsal, single joint	4
28750	Arthrodesis, great toe; metatarsophalangeal joint	4
28755	interphalangeal joint	4
28760	Arthrodesis, great toe, interphalangeal joint, with extensor hallucis longus transfer to first metatarsal neck (Jones type procedure)	4
AMPUTATION		
28810	Amputation, metatarsal, with toe, single	2
28820	Amputation, toe; metatarsophalangeal joint	2
28825	interphalangeal joint	2

ARTHROSCOPY

29804	Arthroscopy, temporomandibular joint, surgical	3
29815	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy	3
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body	3
29820	synovectomy, partial	3
29821	synovectomy, complete	3
29822	debridement, limited	3
29823	debridement, extensive	3
29825	with lysis and resection of adhesions, with or without manipulation	3
29826	decompression of subacromial space with partial acromioplasty, with or without coracoacromial release	3
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy	3
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body	3
29835	synovectomy, partial	3
29836	synovectomy, complete	3
29837	debridement, limited	3
29838	debridement, extensive	3

CPT Procedure Code	Description	Group
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy	3
29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage	3
29844	synovectomy, partial	3
29845	synovectomy, complete	3
29846	excision and/or repair of triangular fibrocartilage and/or joint debridement	3
29847	internal fixation for fracture or instability	3
29850	Arthroscopically aided treatment of intercondylar spine(s) and/or tuberosity fracture(s) of the knee, with or without manipulation; without internal or external fixation (includes arthroscopy)	4
29851	with internal or external fixation (includes arthroscopy)	4
29855	Arthroscopy aided treatment of tibial fracture, proximal (plateau); unicondylar, with or without internal or external fixation (includes arthroscopy)	4
29856	bicondylar, with or without internal or external fixation (includes arthroscopy)	4
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy	3
29871	Arthroscopy, knee, surgical; for infection lavage and drainage	3
29874	for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)	3
29875	synovectomy, limited (eg, plica or shelf resection)	4
29876	synovectomy, major, two or more compartments (eg, medial or lateral)	4
29877	debridement/shaving or articular cartilage (chondroplasty)	4
29879	abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling	3
29880	with meniscectomy (medial AND lateral, including any meniscal shaving)	4
29881	with meniscectomy (medial OR lateral, including any meniscal shaving)	4
29882	with meniscus repair (medial OR lateral)	3
29883	with meniscus repair (medial AND lateral)	3
29884	with lysis of adhesions, with or without manipulation	3
29885	drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)	3
29886	drilling for intact osteochondritis dissecans lesion	3
29887	drilling for intact osteochondritis dissecans lesion with internal fixation	3
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	3
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction	3
29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body	3
29895	synovectomy, partial	3
29897	debridement, limited	3
29898	debridement, extensive	3

RESPIRATORY SYSTEM

NOSE

EXCISION

30115	Excision, nasal polyp(s), extensive	2
30117	Excision or destruction, any method (including laser), intranasal lesion; internal approach	3
30118	external approach (lateral rhinotomy)	3
30120	Excision or surgical planing of skin of nose for rhinophyma	1
30124	Excision dermoid cyst, nose; simple, skin, subcutaneous	1
30125	complex, under bone or cartilage	2
30130	Excision turbinate, partial or complete	3
30140	Submucous resection turbinate, partial or complete	2
30150	Rhinectomy; partial	3
30160	total	4

REMOVAL OF FOREIGN BODY

30310	Removal foreign body, intranasal; requiring general anesthesia	1
30320	by lateral rhinotomy	2

CPT Procedure Code	Description	Group
	REPAIR	
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	4
30540	Repair choanal atresia; intranasal	5
30560	Lysis intranasal synechia	2
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	4
30600	oronasal	4
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	7
30630	Repair nasal septal perforations	7
	DESTRUCTION	
30801	Cauterization and/or ablation, mucosa of turbinates, unilateral or bilateral, any method; superficial	1
30802	intramural	1
	OTHER PROCEDURES	
30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method	1
30905	Control nasal hemorrhage, posterior, with posterior nasal packs and/or cauterization, any method; initial	1
30906	subsequent	1
30915	Ligation arteries; ethmoidal	2
30920	internal maxillary artery, transantral	3

ACCESSORY SINUSES

	INCISION	
31020	Sinusotomy, maxillary (antrotomy); intranasal	2
31030	radical (Caldwell-Luc) without removal of antrochoanal polyps	3
31032	radical (Caldwell-Luc) with removal of antrochoanal polyps	4
31050	Sinusotomy, sphenoid, with or without biopsy;	2
31051	with mucosal stripping or removal of polyp(s)	4
31070	Sinusotomy frontal; external, simple (trephine operation)	2
31075	transorbital, unilateral (for mucocele or osteoma, Lynch type)	4
31080	obliterative without osteoplastic flap, brow incision (includes ablation)	4
31084	obliterative, with osteoplastic flap, brow incision	4
31086	nonobliterative, with osteoplastic flap, brow incision	4
31090	Sinusotomy combined, three or more sinuses	5
	EXCISION	
31200	Ethmoidectomy; intranasal, anterior	2
31201	intranasal, total	5
31205	extranasal, total	3
	ENDOSCOPY	
31233	Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)	2
31235	Nasal/sinus endoscopy, diagnostic with sphenoid sinuscopy (via puncture of sphenoidal face or cannulation of ostium)	1
31237	Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement	2
31238	with control of epistaxis	1
31239	with dacryocystorhinostomy	4
31240	with concha bullosa resection	2
31254	Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)	3
31255	with ethmoidectomy, total (anterior and posterior)	5
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;	3
31267	with removal of tissue from maxillary sinus	3
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus	3
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;	3
31288	with removal of tissue from the sphenoid sinus	3

CPT Procedure Code	Description	Group

LARYNX

EXCISION

31300	Laryngotomy (thyrotomy, laryngofissure); with removal of tumor or laryngocele, cordectomy	5
31320	diagnostic	2

ENDOSCOPY

31505	Laryngoscopy, indirect; diagnostic	2
31510	with biopsy	2
31511	with removal of foreign body	2
31512	with removal of lesion	2
31513	with vocal cord injection	2
31515	Laryngoscopy direct, with or without tracheoscopy; for aspiration	1
31525	diagnostic, except newborn	1
31526	diagnostic, with operating microscope	2
31527	with insertion of obturator	1
31528	with dilation, initial	2
31529	with dilation, subsequent	2
31530	Laryngoscopy, direct, operative, with foreign body removal;	2
31531	with operating microscope	3
31535	Laryngoscopy, direct, operative, with biopsy;	2
31536	with operating microscope	3
31540	Laryngoscopy, direct, operative, with excision of tumor and/or stripping of vocal cords or epiglottis;	3
31541	with operating microscope	4
31560	Laryngoscopy, direct, operative, with arytenoidectomy;	5
31561	with operating microscope	5
31570	Laryngoscopy, direct, with injection into vocal cord(s), therapeutic;	2
31571	with operating microscope	2
31576	Laryngoscopy, flexible fiberoptic; with biopsy	2
31577	with removal of foreign body	2
31578	with removal of lesion	2

CPT Procedure Code	Description	Group

REPAIR

31580	Laryngoplasty; for laryngeal web, two stage, with keel insertion and removal	5
31582	for laryngeal stenosis, with graft or core mold, including tracheotomy	5
31584	with open reduction of fracture	4
31585	Treatment of closed laryngeal fracture; without manipulation	1
31586	with closed manipulative reduction	2
31588	Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)	5
31590	Laryngeal reinnervation by neuromuscular pedicle	5

DESTRUCTION

31595	Section recurrent laryngeal nerve, therapeutic, unilateral	2

TRACHEA AND BRONCHI

INCISION

31600	Tracheostomy, planned	2
31611	Construction of trachesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, Blom-Singer prosthesis)	3
31612	Tracheal puncture, percutaneous with transtracheal aspiration and/or injection	1
31613	Tracheostoma revision; simple, without flap rotation	2
31614	complex, with flap rotation	2

ENDOSCOPY

31615	Tracheobronchoscopy through established tracheostomy incision	1
31622	Bronchoscopy; diagnostic, (flexible or rigid), with or without cell washing or brushing	1
31625	with biopsy	2
31628	with transbronchial lung biopsy, with or without fluoroscopic guidance	2
31629	with transbronchial needle aspiration biopsy	2
31630	with tracheal or bronchial dilation or closed reduction of fracture	2

CPT Procedure Code	Description	Group
31631	with tracheal dilation and placement of tracheal stent	2
31635	with removal of foreign body	2
31640	with excision of tumor	2
31641	with destruction of tumor or relief of stenosis by any method other than excision (eg, laser)	2
31645	with therapeutic aspiration of tracheo-bronchial tree, initial (eg, drainage of lung abscess)	1
31646	with therapeutic aspiration of tracheo-bronchial tree, subsequent	1
31656	with injection of contrast material for segmental bronchography (fiberscope only)	1

INTRODUCTION

31700	Catheterization, transglottic	1
31710	Catheterization for bronchography, with or without instillation of contrast material	1
31715	Transtracheal injection for bronchography	1
31717	Catheterization with bronchial brush biopsy	1
31720	Catheter aspiration; nasotracheal	1
31730	Transtracheal (percutaneous) introduction of needle wire dilator/stent or indwelling tube for oxygen therapy	1

REPAIR

31750	Tracheoplasty; cervical	5
31755	tracheopharyngeal fistulization, each stage	2
31785	Excision of tracheal tumor or carcinoma; cervical	4
31800	Suture of external tracheal wound or injury; cervical	2
31820	Surgical closure tracheostomy or fistula; without plastic repair	1
31825	with plastic repair	2
31830	Revision of tracheostomy scar	2

LUNGS AND PLEURA

INCISION

32000	Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent	1
32002	Thoracentesis with insertion of tube with or without water seal (eg, for pneumothorax)	2
32005	Chemical pleurodesis (eg, for recurrent or persistent pneumothorax)	2
32020	Tube thoracostomy with or without water seal (eg, for abscess, hemothorax, empyema)	2

EXCISION

32400	Biopsy, pleura; percutaneous needle	1
32405	Biopsy, lung or mediastinum, percutaneous needle	1
32420	Pneumonocentesis, puncture of lung for aspiration	1

CARDIOVASCULAR SYSTEM

HEART AND PERICARDIUM

PERICARDIUM

33010	Pericardiocentesis; initial	2
33011	subsequent	2

ARTERIES AND VEINS

EMBOLECTOMY/THROMBECTOMY

Arterial, With or Without Catheter

34101	Embolectomy or thrombectomy, with or without catheter; axillary, brachial, innominate, subclavian artery, by arm incision	3

VASCULAR INJECTION PROCEDURES

Intra-Arterial--Intra-Aortic

36261	Revision of implanted intra-arterial infusion pump	2
36262	Removal of implanted intra-arterial infusion pump	1

CPT Procedure Code	Description	Group
Venous		
36489	Placement of central venous catheter (subclavian, jugular, or other vein) (eg, for central venous pressure, hyperalimentation, hemodialysis, or chemotherapy); percutaneous, over age 2	1
36491	cutdown, over age 2	1
36530	Insertion of implantable intravenous infusion pump	3
36531	Revision of implantable intravenous infusion pump	2
36532	Removal of implantable intravenous infusion pump	1
36533	Insertion of implantable venous access port, with or without subcutaneous reservoir	3
36534	Revision of implantable venous access port and/or subcutaneous reservoir	2
36535	Removal of implantable venous access port and/or subcutaneous reservoir	1
Arterial		
36640	Arterial catheterization for prolonged infusion therapy (chemotherapy), cutdown	1
INTERVASCULAR CANNULIZATION OR SHUNT		
36800	Insertion of cannula for hemodialysis, other purpose; vein to vein	3
36810	arteriovenous, external (Scribner type)	3
36815	arteriovenous, external revision or closure	3
36821	Arteriovenous anastomosis, direct, any site (eg, Cimino type)	3
36825	Creation of arteriovenous fistula by other than direct arteriovenous anastomosis; autogenous graft	4
36830	nonautogenous graft	4
36832	Revision of an arteriovenous fistula, without thrombectomy, autogenous or non-autogenous dialysis graft	4
36833	with thrombectomy, autogenous or nonautogenous dialysis graft	4
36835	Insertion of Thomas shunt	4
36860	Cannula declotting; without balloon catheter	2
36861	with balloon catheter	3
LIGATION AND OTHER PROCEDURES		
37609	Ligation or biopsy, temporal artery	2
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	2
37720	Ligation and division and complete stripping of long or short saphenous veins	3
37730	Ligation and division and complete stripping of long or short saphenous veins	3
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia	3
37760	Ligation of perforators, subfascial, radical (Linton type), with or without skin graft	3
37780	Ligation and division of short saphenous vein at saphenopopliteal junction	3
37785	Ligation, division and/or excision of recurrent or secondary varicose veins (clusters), one leg	3

HEMIC AND LYMPHATIC SYSTEM

LYMPH NODES AND LYMPHATIC CHANNELS

INCISION

38300	Drainage of lymph node abscess or lymphadenitis; simple	1
38305	extensive	2
38308	Lymphangiotomy or other operations on lymphatic channels	2

EXCISION

38500	Biopsy or excision of lymph node(s); superficial	2
38505	by needle, superficial (eg, cervical, inguinal, axillary)	1
38510	deep cervical node(s)	2
38520	deep cervical node(s) with excision scalene fat pad	2
38525	deep axillary node(s)	2

CPT Procedure Code	Description	Group
38530	internal mammary node(s)	2
38542	Dissection; deep jugular node(s)	2
38550	Excision of cystic hygroma, axillary or cervical; without deep neurovascular dissection	3
38555	with deep neurovascular dissection	4
	RADICAL LYMPHADENECTOMY (RADICAL RESECTION OF LYMPH NODES)	
38700	Suprahyoid lymphadenectomy	2
38740	Axillary lymphadenectomy; superficial	2
38745	complete	4
38760	Inguinofemoral lymphadenectomy, superficial, including Cloquet's node	2
	INTRODUCTION	
38790	Injection procedure for lymphangiography	1

DIGESTIVE SYSTEM

LIPS

EXCISION

40500	Vermilionectomy (lip shave), with mucosal advancement	2
40510	Excision of lip; transverse wedge excision with primary closure	2
40520	V-excision with primary direct linear closure	2
40525	full thickness, reconstruction with local flap (eg, Estlander or fan)	2
40527	full thickness, reconstruction with cross lip flap (Abbe-Estlander)	2
40530	Resection of lip, more than one-fourth, without reconstruction	2

REPAIR (CHEILOPLASTY)

40650	Repair lip, full thickness; vermilion only	3
40652	up to half vertical height	3
40654	over one-half vertical height, or complex	3

CPT Procedure Code	Description	Group

VESTIBULE OF MOUTH

INCISION

40801	Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated	2
40805	Removal of embedded foreign body, vestible of mouth; complicated	2
40806	Incision of labial frenum (frenotomy)	1

EXCISION, DESTRUCTION

40814	Excision of lesion of mucosa and submucosa, vestibule of mouth; with complex repair	2
40816	complex, with excision of underlying muscle	2
40818	Excision of mucosa of vestibule of mouth as donor graft	1
40819	Excision of frenum, labial or buccal (frenumectomy, frenulectomy, frenectomy)	1
40820	Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)	1

REPAIR

40831	Closure of laceration, vestibule of mouth; over 2.5 cm or complex	1
40840	Vestibuloplasty; anterior	2
40842	posterior, unilateral	3
40843	posterior, bilateral	3
40844	entire arch	5
40845	complex (including ridge extension, muscle repositioning)	5

TONGUE AND FLOOR OF MOUTH

INCISION

41000	Intraoral incision and drainage of abscess, cyst, or hematoma of tongue or floor of mouth; lingual	1
41005	sublingual, superficial	1
41006	sublingual, deep, supramylohyoid	1
41007	submental space	1
41008	submandibular space	1
41009	masticator space	1
41010	Incision of lingual frenum (frenotomy)	1

CPT Procedure Code	Description	Group
41015	Extraoral incision and drainage of abscess, cyst, or hematoma of floor of mouth; sublingual	1
41016	submental	1
41017	submandibular	1
41018	masticator space	1
	EXCISION	
41100	Biopsy of tongue; anterior two-thirds	1
41105	posterior one-third	2
41110	Excision of lesion of tongue without closure	1
41112	Excision of lesion of tongue with closure; anterior two-thirds	2
41113	posterior one-third	2
41114	with local tongue flap	2
41115	Excision of lingual frenum (frenectomy)	1
41116	Excision, lesion of floor of mouth	1
41120	Glossectomy; less than one-half tongue	5
	REPAIR	
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	2
41251	posterior one-third of tongue	2
41252	Repair of laceration of tongue, floor of mouth, over 2.6 cm or complex	2
	OTHER PROCEDURES	
41500	Fixation of tongue, mechanical, other than suture (eg, K-wire)	1
41510	Suture of tongue to lip for micrognathia (Douglas type procedure)	1
41520	Frenoplasty (surgical revision of frenum, eg, with Z-plasty)	2

DENTOALVEOLAR STRUCTURES

CPT Procedure Code	Description	Group
	INCISION	
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures	1
41805	Removal of embedded foreign body from dentoalveolar structures; soft tissues	1
41806	bone	1
	EXCISION, DESTRUCTION	
41825	Excision of lesion or tumor (except listed above), dentoalveolar structures; without repair	2
41826	with simple repair	2
41827	with complex repair	2

PALATE, UVULA

CPT Procedure Code	Description	Group
	INCISION	
42000	Drainage of abscess of palate, uvula	2
	EXCISION, DESTRUCTION	
42104	Excision, lesion of palate, uvula; without closure	2
42106	with simple primary closure	2
42107	with local flap closure	2
42120	Resection of palate or extensive resection of lesion	4
42140	Uvulectomy, excision of uvula	2
42145	Palatopharyngoplasty (eg, uvulopalato-pharyngoplasty, uvulopharyngoplasty)	5
42160	Destruction of lesion, palate or uvula (thermal, cryo or chemical)	1
	REPAIR	
42180	Repair, laceration of palate; up to 2 cm	1
42182	over 2 cm or complex	2
42200	Palatoplasty for cleft palate, soft and/or hard palate only	5
42205	Palatoplasty for cleft palate, with closure of alveolar ridge; soft tissue only	5
42210	with bone graft to alveolar ridge (includes obtaining graft)	5
42215	Palatoplasty for cleft palate; major revision	7
42220	secondary lengthening procedure	5
42225	attachment pharyngeal flap	5
42235	Repair of anterior palate, including vomer flap	5
42260	Repair of nasolabial fistula	4
42281	Insertion of pin-retained palatal prosthesis	3

CPT Procedure Code	Description	Group

SALIVARY GLAND AND DUCTS

INCISION

42300	Drainage of abscess; parotid, simple	1
42305	parotid, complicated	2
42310	Drainage of abscess; submaxillary or sublingual, intraoral	1
42320	submaxillary, external	1
42325	Fistulization of sublingual salivary cyst (ranula)	2
42335	Sialolithotomy; submandibular (submaxillary), complicated, intraoral	3
42340	parotid, extraoral or complicated intraoral	2

EXCISION

42405	Biopsy of salivary gland; incisional	2
42408	Excision of sublingual salivary cyst (ranula)	3
42409	Marsupialization of sublingual salivary cyst (ranula)	3
42410	Excision of parotid tumor or parotid gland; lateral lobe, without nerve dissection	3
42420	total, with dissection and preservation of facial nerve	7
42425	total, en bloc removal with sacrifice of facial nerve	7
42440	Excision of submandibular (submaxillary) gland	3
42450	Excision of sublingual gland	2

REPAIR

42500	Plastic repair of salivary duct, sialodochoplasty; primary or simple	3
42505	secondary or complicated	4
42507	Parotid duct diversion, bilateral (Wilke type procedure);	3
42508	with excision of one submandibular gland	4
42509	with excision of both submandibular glands	4
42510	with ligation of both submandibular (Wharton's) ducts	4

CPT Procedure Code	Description	Group

OTHER PROCEDURES

42600	Closure salivary fistula	1

PHARYNX, ADENOIDS, AND TONSILS

INCISION

42700	Incision and drainage abscess; peritonsillar	1
42720	retropharyngeal or parapharyngeal, intraoral approach	1
42725	retropharyngeal or parapharyngeal, external approach	2

EXCISION, DESTRUCTION

42802	Biopsy; hypopharynx	1
42804	nasopharynx, visible lesion, simple	1
42806	nasopharynx, survey for unknown primary lesion	2
42808	Excision or destruction of lesion of pharynx, any method	2
42810	Excision branchial cleft cyst or vestige, confined to skin and subcutaneous tissues	3
42815	Excision branchial cleft cyst, vestige, or fistula, extending beneath subcutaneous tissues and/or into pharynx	5
42820	Tonsillectomy and adenoidectomy; under age 12	5
42821	age 12 or over	5
42825	Tonsillectomy, primary or secondary; under age 12	5
42826	age 12 or over	5
42830	Adenoidectomy, primary; under age 12	4
42831	age 12 or over	4
42835	Adenoidectomy, secondary; under age 12	4
42836	age 12 or over	4
42860	Excision of tonsil tags	3
42870	Excision or destruction lingual tonsil, any method	3

REPAIR

42900	Suture pharynx for wound or injury	1

CPT Procedure Code	Description	Group
42950	Pharyngoplasty (plastic or reconstructive operation on pharynx)	2
	OTHER PROCEDURES	
42955	Pharyngostomy (fistulization of pharynx, external for feeding)	2
42960	Control oropharyngeal hemorrhage, primary or secondary (eg, posttonsillectomy); simple	1
42962	with secondary surgical intervention	2

ESOPHAGUS

ENDOSCOPY

43200	Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing	1
43202	with biopsy, single or multiple	1
43204	with injection sclerosis of esophageal varices	1
43215	with removal of foreign body	1
43216	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	1
43217	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	1
43219	with insertion of plastic tube or stent	1
43220	with balloon dilation (less than 30 mm diameter)	1
43226	with insertion of guide wire followed by dilation over guide wire	1
43228	with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	2
43234	Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope)	1
43235	Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing	1
43239	with biopsy, single or multiple	2
43241	with transendoscopic tube or catheter placement	2
43243	with injection sclerosis of esophageal and/or gastric varices	2
43245	with dilation of gastric outlet for obstruction, any method	2
43246	with directed placement of percutaneous gastrostomy tube	2
43247	with removal of foreign body	2
43248	with insertion of guide wire followed by dilation of esophagus over guide wire	2
43249	with balloon dilation of esophagus (less than 30 mm diameter)	2
43250	with removal of tumor(s), polyp(s), or other lesion(s) by hot bopsy forceps or bipolar cautery	2
43251	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2
43255	with control of bleeding, any method	2
43258	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	3
43259	with endoscopic ultrasound examination	3
43260	Endoscopic retrograde cholangiopancrea--tography (ERCP); diagnostic, with or without collection of specimen(s) by brushing or washing	2
43261	with biopsy, single or multiple	2
43262	with sphincterotomy/papillotomy	2
43263	with pressure measurement of sphincter of Oddi (pancreatic duct or common bile duct)	2
43264	with endoscopic retrograde removal of stone(s) from biliary and/or pancreatic ducts	2
43265	with endoscopic retrograde destruction, lithotripsy of stone(s), any method	2
43267	with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube	2
43268	with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct	2
43269	with endoscopic retrograde removal of foreign body and/or change of tube or stent	2
43271	with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)	2
43272	with ablation of tumor(s), poly(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	2

MANIPULATION

43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	1
43453	Dilation of esophagus, over guide wire	1
43456	Dilation of esophagus, by balloon or dilators, retrograde	2
43458	Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia	2

CPT Procedure Code	Description	Group

STOMACH

EXCISION

43600	Biopsy of stomach; by capsule, tube, peroral (one or more specimens)	1

INTRODUCTION

43750	Percutaneous placement of gastrostomy tube	2
43760	Change of gastrostomy tube	1

OTHER PROCEDURES

43870	Closure of gastrostomy, surgical	1

INTESTINES (EXCEPT RECTUM)

EXCISION

44100	Biopsy of intestine by capsule, tube, peroral (one or more specimens)	1

ENTEROSTOMY - EXTERNAL FISTULIZATION OF INTESTINES

44312	Revision of ileostomy; simple (release of superficial scar)	1
44340	Revision of colostomy; simple (release of superficial scar)	3
44345	complicated (reconstruction in-depth)	4
44346	with repair of paracolostomy hernia	4

ENDOSCOPY, SMALL BOWEL AND STOMAL

44360	Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing	2
44361	with biopsy, single or multiple	2
44363	with removal of foreign body	2
44364	with removal of tumor(s), polyp(s), or other lesions(s) by snare technique	2
44365	with removal of tumor(s), polyp(s), or other lesions(s) by hot biopsy forceps or bipolar cautery	2
44366	with control of bleeding, any method	2
44369	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	2
44372	with placement of percutaneous jejunostomy tube	2
44373	with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube	2
44380	Ileoscopy, through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing	1
44382	with biopsy, single or multiple	1
44385	Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing	1
44386	with biopsy, single or multiple	1
44388	Colonoscopy through stoma; diagnostic, with or without collection of specimen(s) by brushing or washing	1
44389	with biopsy, single or multiple	1
44390	with removal of foreign body	1
44391	with control of bleeding, any method	1
44392	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	1
44393	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, biopolar cautery or snare technique	1
44394	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	1

RECTUM

INCISION

45000	Transrectal drainage of pelvic abscess	1
45005	Incision and drainage of submucosal abscess, rectum	2
45020	Incision and drainage of deep supralevator, pelvirectal, or retrorectal abscess	2

EXCISION

45100	Biopsy of anorectal wall, anal approach (eg, congenital megacolon)	1
45108	Anorectal myomectomy	2
45150	Division of stricture of rectum	2
45170	Excision of rectal tumor, transanal approach	2

ENDOSCOPY

45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	1

CPT Procedure Code	Description	Group
45307	with removal of foreign body	1
45308	with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1
45309	with removal of single tumor, polyp, or other lesion by snare technique	1
45315	with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	1
45317	with control bleeding, any method	1
45320	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removable by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)	1
45321	with decompression of volvulus	1
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	1
45332	with removal of foreign body	1
45333	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	1
45334	with control of bleeding, any method	1
45337	with decompression of volvulus, any method	1
45338	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	1
45339	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	1
45355	Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple	1
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression	2
45379	with removal of foreign body	2
45380	with biopsy, single or multiple	2
45382	with control of bleeding, any method	2
45383	with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique	2
45384	with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	2
45385	with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	2
REPAIR		
45500	Proctoplasty; for stenosis	2
45505	for prolapse of mucous membrane	2
45560	Repair of rectocele	2

CPT Procedure Code	Description	Group
MANIPULATION		
45900	Reduction of procidentia under anesthesia	1
45905	Dilation of anal sphincter under anesthesia other than local	1
45910	Dilation of rectal stricture under anesthesia other than local	1
45915	Removal of fecal impaction or foreign body under anesthesia	1
ANUS		
INCISION		
46030	Removal of anal seton, other marker	1
46040	Incision and drainage of ischiorectal and/or perirectal abscess	3
46045	Incision and drainage of intramural, intramuscular, or submucosal abscess, transanal, under anesthesia	2
46050	Incision and drainage, perianal abscess, superficial	1
46060	Incision and drainage of ischiorectal or intramural abscess, with fistulectomy or fistulotomy, submuscular, with or without placement of seton	2
46080	Sphincterotomy, anal, division of sphincter	3
EXCISION		
46200	Fissurectomy, with or without sphincterotomy	2
46210	Cryptectomy; single	2
46211	multiple	2
46220	Papillectomy or excision of single tag, anus	1
46250	Hemorrhoidectomy, external, complete	3
46255	Hemorrhoidectomy, internal and external, simple;	3
46257	with fissurectomy	3
46258	with fistulectomy, with or without fissurectomy	3
46260	Hemorrhoidectomy, internal and external, complex or extensive	3
46261	with fissurectomy	4

CPT Procedure Code	Description	Group
46262	with fistulectomy, with or without fissurectomy	4
46270	Surgical treatment of anal fistula (fistulectomy/fistulotomy); subcutaneous	3
46275	submuscular	3
46280	complex or multiple, with or without placement of seton	4
46285	second stage	1

ENDOSCOPY

46608	Anoscopy; with removal of foreign body	1
46610	with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	1
46611	with removal of single tumor, polyp, or other lesion by snare technique	1
46612	with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	1

REPAIR

46700	Anoplasty, plastic operation for stricture; adult	3
46750	Sphincteroplasty, anal, for incontinence or prolapse; adult	3
46753	Graft (Thiersch operation) for rectal incontinence and/or prolapse	3
46754	Removal of Thiersch wire or suture, anal canal	2
46760	Sphincteroplasty, anal, for incontinence, adult, muscle transplant	2

DESTRUCTION

46922	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; surgical excision	1
46924	Destruction of lesion(s), anus (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method	1
46937	Cryosurgery of rectal tumor; benign	2
46938	malignant	2

LIVER

INCISION

47000	Biopsy of liver; needle, percutaneous	1

CPT Procedure Code	Description	Group

BILIARY TRACT

INTRODUCTION

47510	Introduction of percutaneous transhepatic catheter for biliary drainage	2
47525	Change of percutaneous biliary drainage catheter	1
47530	Revision and/or reinsertion of transhepatic tube	1

ENDOSCOPY

47552	Biliary endoscopy, percutaneous via T-tube or other tract; diagnostic, with or without collection of specimen(s) by brushing and/or washing	2
47553	with biopsy, single or multiple	3
47554	with removal of stone(s)	3
47555	with dilation of biliary duct stricture(s) without stent	3

LAPAROSCOPY

47560	Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy	3
47561	with guided transhepatic cholangiography with biopsy	3
47562	cholecystectomy	5
47563	cholecystectomy with cholangiography	5
47564	cholecystectomy with exploration of common duct	5

EXCISION

47630	Biliary duct stone extraction, percutaneous via T-tube tract, basket or snare (eg, Burhenne technique)	3

PANCREAS

EXCISION

48102	Biopsy of pancreas, percutaneous needle	1

ABDOMEN, PERITONEUM, AND OMENTUM

INCISION

49000	Exploratory laparotomy, exploratory celiotomy with or without biopsy(s)	4

CPT Procedure Code	Description	Group
49080	Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial	2
49081	subsequent	2
49085	Removal of peritoneal foreign body from peritoneal cavity	2
	EXCISION, DESTRUCTION	
49180	Biopsy, abdominal or retroperitoneal mass, percutaneous needle	1
49250	Umbilectomy, omphalectomy, excision of umbilicus	4
	LAPAROSCOPY	
49320	Laparoscopy, surgical, abdomen, peritoneum, and omentum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	3
49321	with biopsy (single or multiple)	4
49322	with aspiration of cavity or cyst (eg, ovarion cyst) (single or multiple)	4
	INTRODUCTION, REVISION AND/OR REMOVAL	
49400	Injection of air or contrast into peritoneal cavity	1
49420	Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary	1
49421	permanent	1
49425	Insertion of peritoneal-venous shunt	2
49426	Revision of peritoneal-venous shunt	2
	REPAIR HERNIOPLASTY, HERNIORRHAPHY, HERNIOTOMY	
49500	Repair initial inguinal hernia, age 6 months to under 5 years, with or without hydrocelectomy; reducible	4
49505	Repair initial inguinal hernia, age 5 or over; reducible	4
49520	Repair recurrent inguinal hernia, any age; reducible	7
49525	Repair inguinal hernia, sliding, any age	4
49540	Repair lumbar hernia	2
49550	Repair initial femoral hernia, any age; reducible	5
49555	Repair recurrent femoral hernia; reducible	5
49560	Repair initial incisional or ventral hernia; reducible	4
49565	Repair recurrent incisional or ventral hernia; reducible	4
49570	Repair epigastric hernia (eg, preperitoneal fat); reducible	4
49580	Repair umbililical hernia, under age 5 years; reducible	5
49585	Repair umbilical hernia, age 5 years or over; reducible	4
49587	incarcerated or strangulated	4
49590	Repair spigelian hernia	3
	LAPARASCOPY	
49650	Laparoscopy, surgical; repair initial inguinal hernia	4
49651	repair recurrent inguinal hernia	7

URINARY SYSTEM

KIDNEY

INCISION

50020	Drainage of perirenal or renal abscess; open	2
50040	Nephrostomy, nephrotomy with drainage	3
	EXCISION	
50200	Renal biopsy; percutaneous, by trocar or needle	1
	INTRODUCTION	
50390	Aspiration and/or injection of renal cyst or pelvis by needle, percutaneous	1
50392	Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous	1
50393	Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous	1

CPT Procedure Code	Description	Group
50395	Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous	1
50396	Manometric studies through nephrostomy or pyelostomy tube, or indwelling ureteral catheter	1
50398	Change of nephrostomy or pyelostomy tube	1
	REPAIR	
50520	Closure of nephrocutaneous or pyelocutaneous fistula	1
	ENDOSCOPY	
50551	Renal endoscopy through established nephrostomy or pyelostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	1
50553	with ureteral catheterization, with or without dilation of ureter	1
50555	with biopsy	1
50557	with fulguration and/or incision, with or without biopsy	1
50559	with insertion of radioactive substance with or without biopsy and/or fulguration	1
50561	with removal of foreign body or calculus	1
50570	Renal endoscopy through nephrotomy or pyelotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	1
50572	with ureteral catheterization, with or without dilation of ureter	1
50574	with biopsy	1
50576	with fulguration and/or incision, with or without biopsy	1
50578	with insertion of radioactive substance, with or without biopsy and/or fulguration	1
50580	with removal of foreign body or calculus	1
	OTHER PROCEDURES	
50590	Lithotripsy, extracorporeal shock wave	8

URETER

	INTRODUCTION	
50684	Injection procedure for ureterography or ureteropyelography through ureterostomy or indwelling ureteral catheter	1
50688	Change of ureterostomy tube	1
50690	Injection procedure for visualization of ileal conduit and/or ureteropyelography, exclusive of radiologic service	1
	ENDOSCOPY	
50951	Ureteral endoscopy through established ureterostomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	1
50953	with ureteral catheterization, with or without dilation of ureter	1
50955	with biopsy	1
50957	with fulguration and/or incision, with or without biopsy	1
50959	with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)	1
50961	with removal of foreign body or calculus	1
50970	Ureteral endoscopy through ureterotomy, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	1
50972	with ureteral catheterization, with or without dilation of ureter	1
50974	with biopsy	1
50976	with fulguration and/or incision, with or without biopsy	1
50978	with insertion of radioactive substance, with or without biopsy and/or fulguration (not including provision of material)	1
50980	with removal of foreign body or calculus	1

BLADDER

	INCISION	
51005	Aspiration of bladder; by trocar or intracatheter	1
51010	with insertion of suprapubic catheter	1
51020	Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material	4
51030	with cryosurgical destruction of intravesical lesion	4
51040	Cystotomy, cystostomy with drainage	4
51045	Cystotomy, with insertion of ureteral catheter or stent	4
	EXCISION	
51500	Excision of urachal cyst or sinus, with or without umbilical hernial repair	4

CPT Procedure Code	Description	Group
INTRODUCTION		
51600	Injection procedure for cystography or voiding urethrocystography	1
51605	Injection procedure and placement of chain for contrast and/or chain urethrocystography	1
51610	Injection procedure for retrograde urethrocystography	1
51710	Change of cystostomy tube; complicated	1
51715	Endoscopic injection implant material into the submucosal tissues of the uretha and/or bladder neck	1
URODYNAMICS		
51725	Simple cystometrogram (CMG) (eg, spinal manometer)	1
51726	Complex cystometrogram (eg, calibrated electronic equipment)	1
51772	Urethral pressure profile studies (UPP) (urethral closure pressure profile), any technique	1
51785	Needle electromyography studies (EMG) of anal or urethral sphincter, any technique	1
REPAIR		
51865	Cystorrhaphy, suture of bladder wound, injury or rupture; complicated	4
51880	Closure of cystostomy	1
51900	Closure of vesicovaginal fistula, abdominal approach	4
51920	Closure of vesicouterine fistula	3
ENDOSCOPY-CYSTOSCOPY, URETHROSCOPY, CYSTOURETHROSCOPY		
52000	Cystourethroscopy	1
52005	Cystourethroscopy, with ureteral catheterization, with or without irrigation, instillation, or ureteropyelography, exclusive of radiologic service;	2
52007	with brush biopsy of ureter and/or renal pelvis	2
52010	Cystourethroscopy, with ejaculatory duct catheterization, with or without irrigation, instillation, or duct radiography, exclusive of radiologic service	2

CPT Procedure Code	Description	Group
TRANSURETHRAL SURGERY		
Urethra and Bladder		
52204	Cystourethroscopy, with biopsy	2
52214	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra or periurethral glands	2
52224	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of MINOR (less than 0.5 cm) lesion(s) with or without biopsy	2
52234	Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)	2
52235	MEDIUM bladder tumor(s) (2.0 to 5.0 cm)	3
52240	LARGE bladder tumor(s)	3
52250	Cystourethroscopy with insertion of radioactive substance, with or without biopsy or fulguration	4
52260	Cystourethroscopy, with dilation of bladder for interstitial cystitis; general or conduction (spinal) anesthesia	2
52270	Cystourethroscopy, with internal urethrotomy; female	2
52275	male	2
52276	Cystourethroscopy with direct vision internal urethrotomy	3
52277	Cystourethroscopy, with resection of external sphincter (sphincterotomy)	2
52281	Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female	2
52283	Cystourethroscopy, with steroid injection into stricture	2
52285	Cystourethroscopy, for treatment of the female urethral syndrome with any or all of the following: urethral meatotomy, urethral dilation, internal urethrotomy, lysis of urethrovaginal septal fibrosis, lateral incisions of the bladder neck, and fulguration of polyp(s) of urethra, bladder neck, and/or trigone	2

CPT Procedure Code	Description	Group
52290	Cystourethroscopy; with ureteral meatotomy, unilateral or bilateral	2
52300	with resection or fulguration of ureterocele(s), unilateral or bilateral	2
52305	with incision or resection of orifice of bladder diverticulum, single or multiple	2
52310	Cystourethroscopy, with removal of foreign body, calculus, or ureteral stent from urethra or bladder; simple	2
52315	complicated	2
52317	Litholapaxy: crushing or fragmentation of calculus by any means in bladder and removal of fragments; simple or small (less than 2.5 cm)	1
52318	complicated or large (over 2.5 cm)	2
Ureter and Pelvis		
52320	Cystourethroscopy (including ureteral catheterization); with removal of ureteral calculus	5
52325	with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)	4
52330	with manipulation, without removal of ureteral calculus	2
52332	Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)	2
52334	Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde	3
52335	Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method);	3
52336	with removal or manipulation of calculus (uretheral catheterization is included)	4
52337	with lithrotripsy (ureteral catheterization is included)	4
52338	with biopsy and/or fulguration of lesion	4
Vesical Neck and Prostate		
52340	Cystourethroscopy with incision, fulguration, or resection of bladder neck and/or posterior urethra (congenital valves, obstructive hypertrophic mucosal folds)	3
52450	Transurethral incision of prostate	3
52500	Transurethral resection of bladder neck	3
52601	Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)	4
52606	Transurethral fulguration for postoperative bleeding occurring after the usual follow-up time	1
52612	Transurethral resection of prostate; first stage of two-stage resection (partial resection)	2
52614	second stage of two-stage resection (resection completed)	1
52620	Transurethral resection; of residual obstructive tissue after 90 days postoperative	1
52630	of regrowth of obstructive tissue longer than one year postoperative	2
52640	of postoperative bladder neck contracture	2
52700	Transurethral drainage of prostatic abscess	2

URETHRA

INCISION

53000	Urethrotomy or urethrostomy, external; pendulous urethra	1
53010	perineal urethra, external	1
53020	Meatotomy, cutting of meatus; except infant	1
53040	Drainage of deep periurethral abscess	2

EXCISION

53200	Biopsy of urethra	1
53210	Urethrectomy, total, including cystostomy; female	5
53215	male	5
53220	Excision or fulguration of carcinoma of urethra	2
53230	Excision of urethral diverticulum; female	2
53235	male	3
53240	Marsupialization of urethral diverticulum, male or female	2

CPT Procedure Code	Description	Group
53250	Excision of bulbourethral gland (Cowper's gland)	2
53260	Excision or fulguration; urethral polyp(s), distal urethra	2
53265	urethral caruncle	2
53275	urethral prolapse	2

REPAIR

53400	Urethroplasty; first stage, for fistula, diverticulum, or stricture, (eg, Johannsen type)	3
53405	second stage (formation of urethra), including urinary diversion	2
53410	Urethroplasty, one-stage reconstruction of male anterior urethra	2
53420	Urethroplasty, two-stage reconstruction or repair of prostatic or membranous urethra; first stage	3
53425	second stage	2
53430	Urethroplasty, reconstruction of female urethra	2
53440	Operation for correction of male urinary incontinence, with or without introduction of prosthesis	2
53442	Removal of perineal prosthesis introduced for continence	1
53447	Removal, repair, or replacement of inflatable sphincter including pump and/or reservoir and/or cuff	1
53449	Surgical correction of hydraulic abnormality of inflatable sphincter device	1
53450	Urethromeatoplasty, with mucosal advancement	1
53460	with partial excision of distal urethral segment (Richardson type procedure)	1
53502	Urethrorrhaphy, suture of urethral wound or injury, female	2
53505	Urethrorrhaphy, suture of urethral wound or injury; penile	2
53510	perineal	2
53515	prostatomembranous	2
53520	Closure of urethrostomy or urethrocutaneous fistula, male	2

CPT Procedure Code	Description	Group

MANIPULATION

53605	Dilation of urethral stricture or vesical neck by passage of sound or urethral dilator, male, general or conduction (spinal) anesthesia	2
53665	Dilation of female urethra, general or conduction (spinal) anesthesia	1

MALE GENITAL SYSTEM

PENIS

INCISION

54001	Slitting of prepuce, dorsal or lateral; except newborn	2
54015	Incision and drainage of penis, deep	4

DESTRUCTION

54057	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery	1
54060	surgical excision	1
54065	Destruction of lesion(s), penis (eg, condyloma, papilloma, molluscum contagiosum, herpetic vesicle), extensive, any method	1

EXCISION

54100	Biopsy of penis; cutaneous	1
54105	deep structures	1
54110	Excision of penile plaque (Peyronie disease)	2
54115	Removal foreign body from deep penile tissue (eg, plastic implant)	1
54120	Amputation of penis; partial	2
54125	complete	2
54152	Circumcision, using clamp or other device; except newborn. **Limited to diagnosis codes 605, 607.1, and 607.81.**	1
54161	Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn. **Limited to diagnosis codes 605, 607.1, and 607.81.**	2

CPT Procedure Code	Description	Group
INTRODUCTION		
54205	Injection procedure for Peyronie disease; with surgical exposure of plaque	4
54220	Irrigation of corpora cavernosa for priapism	1
REPAIR		
54300	Plastic operation of penis for straightening of chordee (eg, hypospadias), with or without mobilization of urethra.	3
54360	Plastic operation on penis to correct angulation	3
54420	Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral.	4
54435	Corpora cavernosa-glans penis fistulization (eg, biopsy needle, Winter procedure, rongeur, or punch) for priapism	4
54440	Plastic operation of penis for injury.	4
MANIPULATION		
54450	Foreskin manipulation including lysis of preputial adhesions and stretching	1

TESTIS

EXCISION		
54500	Biopsy of testis, needle	1
54505	Biopsy of testis, incisional	1
54510	Excision of local lesion of testis	2
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach	3
54530	Orchiectomy, radical, for tumor; inguinal approach	4
54550	Exploration for undescended testis (inguinal or scrotal area)	4
REPAIR		
54600	Reduction of torsion of testis, surgical, with or without fixation of contralateral testis	4
54620	Fixation of contralateral testis	3
54640	Orchiopexy, inguinal approach, with or without hernia repair	4
54670	Suture or repair of testicular injury	3
54680	Transplantation of testis(es) to thigh (because of scrotal destruction)	3

EPIDIDYMIS

INCISION		
54700	Incision and drainage of epididymis, testis and/or scrotal space (eg, abscess or hematoma)	2
EXCISION		
54800	Biopsy of epididymis, needle	1
54820	Exploration of epididymis, with or without biopsy	1
54830	Excision of local lesion of epididymis	3
54840	Excision of spermatocele, with or without epididymectomy	4
54860	Epididymectomy; unilateral	3
54861	bilateral	4
REPAIR		
54900	Epididymovasostomy, anastomosis of epididymis to vas deferens; unilateral	4
54901	bilateral	4

TUNICA VAGINALIS

EXCISION		
55040	Excision of hydrocele; unilateral	3
55041	bilateral	5
REPAIR		
55060	Repair of tunica vaginalis hydrocele (Bottle type)	4

SCROTUM

INCISION		
55100	Drainage of scrotal wall abscess	1
55110	Scrotal exploration	2
55120	Removal of foreign body in scrotum	2

CPT Procedure Code	Description	Group

EXCISION

55150	Resection of scrotum	1

REPAIR

55175	Scrotoplasty; simple	1
55180	complicated	2

VAS DEFERENS

INCISION

55200	Vasotomy, cannulization with or without incision of vas, unilateral or bilateral	2

EXCISION

55250	Vasectomy, unilateral or bilateral, including postoperative semen examination(s)	4

SPERMATIC CORD

EXCISION

55500	Excision of hydrocele of spermatic cord, unilateral	3
55520	Excision of lesion of spermatic cord	4
55530	Excision of varicocele or ligation of spermatic veins for varicocele;	4
55535	abdominal approach	4
55540	with hernia repair	5

SEMINAL VESICLES

INCISION

55600	Vesiculotomy;	1
55605	complicated	1

EXCISION

55650	Vesiculectomy, any approach	1
55680	Excision of Mullerian duct cyst	1

CPT Procedure Code	Description	Group

PROSTATE

INCISION

55700	Biopsy, prostate; needle or punch, single or multiple, any approach	2
55705	incisional, any approach	2
55720	Prostatotomy, external drainage of prostatic abscess, any approach; simple	1

FEMALE GENITAL SYSTEM

VULVA, PERINEUM AND INTROITUS

INCISION

56405	Incision and drainage of vulva or perineal abscess	2
56440	Marsupialization of Bartholin's gland cyst	2
56441	Lysis of labial adhesions	1

DESTRUCTION

56515	Destruction of lesion(s), vulva; extensive, any method	3

EXCISION

56605	Biopsy of vulva or perineum; one lesion	1
56620	Vulvectomy, simple; partial	5
56625	complete	7
56700	Partial hymenectomy or revision of hymenal ring	1
56720	Hymenotomy, simple incision	1
56740	Excision of Bartholin's gland or cyst	3

REPAIR

56800	Plastic repair of introitus	3
56810	Perineoplasty, repair of perineum, non-obstetrical	5

VAGINA

INCISION

57000	Colpotomy; with exploration	1

CPT Procedure Code	Description	Group
57010	with drainage of pelvic abscess	2
57020	Colpocentesis	2
	DESTRUCTION	
57061	Destruction of vaginal lesion(s); simple, any method	1
57065	extensive, any method	1
	EXCISION	
57105	Biopsy of vaginal mucosa; extensive, requiring suture (including cysts)	2
57130	Excision of vaginal septum	2
57135	Excision of vaginal cyst or tumor	2
	INTRODUCTION	
57180	Introduction of any hemostatic agent or pack for spontaneous or traumatic nonobstetrical vaginal hemorrhage	1
	REPAIR	
57200	Colporrhaphy, suture of injury of vaginal (nonobstetrical)	1
57210	Colpoperineorrhaphy, suture of injury of vagina and/or perineum (nonobstetrical)	2
57220	Plastic operation on urethral sphincter, vaginal approach (eg, Kelly urethral plication)	3
57230	Plastic repair of urethrocele	3
57240	Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele	5
57250	Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	5
57260	Combined anteroposterior colporrhaphy;	5
57265	with enterocele repair	7
57268	Repair of enterocele, vaginal approach	3
57300	Closure of rectovaginal fistula; vaginal or transanal approach	3
57310	Closure of urethrovaginal fistula;	3
57311	with bulbocavernosus transplant	4
57320	Closure of vesicovaginal fistula; vaginal approach	3

CPT Procedure Code	Description	Group
	MANIPULATION	
57400	Dilation of vagina under anesthesia	2
57410	Pelvic examination under anesthesia	2

CERVIX UTERI

	EXCISION	
57513	Cauterization of cervix; laser ablation	2
57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	2
57522	loop electrode excision	2
57530	Trachelectomy (cervicectomy), amputation of cervix	3
57550	Excision of cervical stump, vaginal approach	3
	REPAIR	
57700	Cerclage of uterine cervix, nonobstetrical	1
57720	Trachelorrhaphy, plastic repair of uterine cervix, vaginal approach	3
	MANIPULATION	
57800	Dilation of cervical canal, instrumental	1
57820	Dilation and curettage of cervical stump	3

CORPUS UTERI

	EXCISION	
58120	Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)	2
58145	Myomectomy, excision of fibroid tumor of uterus, single or multiple; vaginal approach	5
	LAPAROCOPY/HYSTEROSCOPY	
58551	Laparoscopy, surgical; with removal of leiomyomata (single or multiple)	5
58555	Hysteroscopy, diagnostic	1
58558	Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without D&C	3

CPT Procedure Code	Description	Group
58559	with lysis of intrauterine adhesions (any method)	2
58561	with removal of leiomyomata	3
58563	with endometrial ablation (any method)	4

OVIDUCT

INCISION

58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	5
58615	Occlusion of fallopian tube(s) by device (eg, band, clip, Falope ring) vaginal or suprapubic approach	5

OVIDUCT/OVARY

LAPAROSCOPY

58660	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis)	5
58661	with removal of adnexal sturctures (partial or total oophorectomy and/or salpingectomy)	5
58662	with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface by any method	5
58670	with fulguration of oviducts (with or without transection)	3
58671	with occlusion of oviducts by device (eg, band, clip, or Falope ring)	3

INCISION

58800	Drainage of ovarian cyst(s), unilateral or bilateral; vaginal approach	3
58820	Drainage of ovarian abscess; vaginal approach; open	3

EXCISION

58900	Biopsy of ovary, unilateral or bilateral	3

ABORTION

59812	Treatment of incomplete abortion, any trimester, completed surgically	4
59840	Induced abortion, by dilation and curettage	3
59841	Induced abortion, by dilation and evacuation	2

ENDOCRINE SYSTEM

THYROID GLAND

INCISION

60000	Incision and drainage of thyroglossal cyst, infected	1

EXCISION

60200	Excision of cyst or adenoma of thyroid, or transection of isthmus	2
60220	Total thyroid lobectomy, unilateral; with or without isthmusectomy	2
60225	with contralateral subtotal lobectomy, including isthmusectomy	3
60280	Excision of thyroglossal duct cyst or sinus;	4
60281	recurrent	4

NERVOUS SYSTEM

SKULL, MENINGES, AND BRAIN

INJECTION, DRAINAGE, OR ASPIRATION

61020	Ventricular puncture through previous burr hole, fontanelle, suture, or implanted ventricular catheter/reservoir; without injection	1
61026	with injection of drug or other substance for diagnosis or treatment	1
61050	Cisternal or lateral cervical (C1-C2) puncture; without injection	1
61055	with injection of drug or other substance for diagnosis or treatment (eg, C1-C2)	1
61070	Puncture of shunt tubing or reservoir for aspiration or injection procedure	1

TWIST DRILL, BURR HOLE(S), OR TREPHINE

61215	Insertion of subcutaneous reservoir, pump or continuous infusion system for connection to ventricular catheter	3

CPT Procedure Code	Description	Group
	STEREOTAXIS	
61790	Creation of lesion by stereotactic method, percutaneous, by neurolytic agent (eg, alcohol, thermal, electrical, radiofrequency); gasserian ganglion	3
61791	trigeminal medullary tract	3
	CSF SHUNT	
62194	Replacement or irrigation, subarachnoid/ subdural catheter	1
62225	Replacement or irrigation, ventricular catheter	1
62230	Replacement or revision of CSF shunt, obstructed valve, or distal catheter in shunt system	2
62256	Removal of complete CSF shunt system; without replacement	2

SPINE AND SPINAL CORD

	INJECTION, DRAINAGE, OR ASPIRATION	
62268	Percutaneous aspiration, spinal cord cyst or syrinx	1
62269	Biopsy of spinal cord, percutaneous needle	1
62270	Spinal puncture, lumbar, diagnostic	1
62272	Spinal puncture, therapeutic, for drainage of spinal fluid (by needle or catheter)	1
62273	Injection, lumbar epidural, of blood or clot patch	1
62280	Injection of neurolytic substance (eg, alcohol, phenol, iced saline solutions); subarachnoid	1
62282	epidural, lumbar or caudal	1
62294	Injection procedure, arterial, for occlusion of arteriovenous malformation, spinal	3
62310	Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substances(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	1
62311	lumbar, sacral (caudal)	1
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substnaces, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antipsasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic	1
62319	lumbar, sacral (caudal)	1
	CATHETER IMPLANTATION	
62350	Implantation, revision or repositioning of intrathecal or epidural catheter, for implantable reservoir or implantable infusion pump; without laminectomy	2
62351	with laminectomy	2
	RESERVOIR/PUMP IMPLANTATION	
62360	Implantation or replacement of device for intrathecal or epidural drug infustion; subcutaneous reservoir	2
62361	non-programmable pump	2
62362	programmable pump, including preparation of pump, with or without programming	2
62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion	2
62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming	2
62368	with reprogramming	2
	STEREOTAXIS	
63600	Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)	2
63610	Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery	1
	NEUROSTIMULATORS (SPINAL)	
63650	Percutaneous implantation of neurostimulator electrodes; epidural.	2
63660	Revision or removal of spinal neurostimulator electrodes.	1

CPT Procedure Code	Description	Group
63685	Incision and subcutaneous placement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling.	2
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver.	1
	SHUNT, SPINAL CSF	
63744	Replacement, irrigation or revision of lumbosubarachnoid shunt	3
63746	Removal of entire lumbosubarachnoid shunt system without replacement	2

EXTRACRANIAL NERVES, PERIPHERAL NERVES, AND AUTONOMIC NERVOUS SYSTEM

INTRODUCTION/INJECTION OF ANESTHETIC AGENT (NERVE BLOCK), DIAGNOSTIC OR THERAPEUTIC

SOMATIC NERVES

64410	Injection, anesthetic agent; phrenic nerve	1
64415	brachial plexus	1
64417	axillary nerve	1
64420	intercostal nerve, single	1
64421	intercostal nerves, multiple, regional block	1
64430	pudendal nerve	1
64475	Injection, anesthetic agent and/or steriod, paravertebral facet joint or facet joint nerve; lumbar or sacral, single level	1
64476	lumbar or sacral, each additional level (list separately in addition to code for primary procedure)	1

SYMPATHETIC NERVES

64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)	1
64520	lumbar or thoracic (paravertebral sympathetic)	1
64530	celiac plexus, with or without radiologic monitoring	1

NEUROSTIMULATORS (PERIPHERAL NERVE)

64575	Incision for implantation of neurostimulator electrodes; peripheral nerve.	1
64590	Incision and subcutaneous placement of peripheral neurostimulator pulse generator or receiver, direct or inductive coupling.	2
64595	Revision or removal of peripheral neurostimulator pulse generator or receiver.	1

DESTRUCTION BY NEUROLYTIC AGENT (eg, CHEMICAL, THERMAL, ELECTRICAL, RADIO- FREQUENCY)

Somatic Nerves

64600	Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch	1
64605	second and third division branches at foramen ovale	1
64610	second and third division branches at foramen ovale under radiologic monitoring	1
64620	Destruction by neurolytic agent; intercostal nerve	1
64622	paravertebral facet joint nerve, lumbar, single level	1
64623	paravertebral facet joint nerve, lumbar, each additional level	1
64630	pudendal nerve	2

Sympathetic Nerves

64680	Destruction by neurolytic agent, celiac plexus, with or without radiologic monitoring	2

NEUROLOPLASTY (EXPLORATION, NEUROLYSIS OR NERVE DECOMPRESSION

64702	Neuroplasty; digital, one or both, same digit	1
64704	nerve of hand or foot	1
64708	Neuroplasty, major peripheral nerve, arm or leg; other than specified	2
64712	sciatic nerve	2
64713	brachial plexus	2
64714	lumbar plexus	2
64716	Neuroplasty and/or transposition; cranial nerve (specify)	3
64718	ulnar nerve at elbow	2
64719	ulnar nerve at wrist	2
64721	median nerve at carpal tunnel	2
64722	Decompression; unspecified nerve(s) (specify)	1
64726	plantar digital nerve	1

CPT Procedure Code	Description	Group
64727	Internal neurolysis, requiring use of operating microscope (list separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)	1
	TRANSECTION OR AVULSION	
64732	Transection or avulsion of; supraorbital nerve	2
64734	infraorbital nerve	2
64736	mental nerve	2
64738	inferior alveolar nerve by osteotomy	2
64740	lingual nerve	2
64742	facial nerve, differential or complete	2
64744	greater occipital nerve	2
64746	phrenic nerve	2
64771	Transection or avulsion of other cranial nerve, extradural	2
64772	Transection or avulsion of other spinal nerve, extradural	2
	EXCISION	
	Somatic Nerves	
64774	Excision of neuroma; cutaneous nerve, surgically identifiable	2
64776	digital nerve, one or both, same digit	3
64778	digital nerve, each additional digit (list separately by this number)	2
64782	hand or foot, except digital nerve	3
64783	hand or foot each additional nerve, except same digit (list separately by this number)	2
64784	major peripheral nerve, except sciatic	3
64786	sciatic nerve	3
64787	Implantation of nerve end into bone or muscle (list separately in addition to neuroma excision)	2
64788	Excision of neurofibroma or neurolemmoma; cutaneous nerve	3
64790	major peripheral nerve	3
64792	extensive (including malignant type)	3
64795	Biopsy of nerve	2
	Sympathetic Nerves	
64802	Sympathectomy, cervical	2
	NEURORRHAPHY	
64831	Suture of digital nerve, hand or foot; one nerve	4
64832	each additional digital nerve	1
64834	Suture of one nerve, hand or foot; common sensory nerve	2
64835	median motor thenar	3
64836	ulnar motor	3
64837	Suture of each additional nerve, hand or foot	1
64840	Suture of posterior tibial nerve	2
64856	Suture of major peripheral nerve, arm or leg, except sciatic; including transposition	2
64857	without transposition	2
64858	Suture of sciatic nerve	2
64859	Suture of each additional major peripheral nerve	1
64861	Suture of; brachial plexus	3
64862	lumbar plexus	3
64864	Suture of facial nerve; extracranial	3
64865	infratemporal, with or without grafting	4
64870	Anastomosis; facial-phrenic	4
64872	Suture of nerve; requiring secondary or delayed suture (list separately in addition to code for primary neurorrhaphy)	2
64874	requiring extensive mobilization, or transposition of nerve (list separately in addition to code for nerve suture)	3
64876	requiring shortening of bone of extremity (list separately in addition to code for nerve suture)	3
	NEURORRHAPHY WITH NERVE GRAFT	
64890	Nerve graft (includes obtaining graft), single strand, hand or foot; up to 4 cm length	2
64891	more than 4 cm length	2
64892	Nerve graft (includes obtaining graft), single strand, arm or leg; up to 4 cm length	2
64893	more than 4 cm length	2
64895	Nerve graft (includes obtaining graft), multiple strands (cable), hand or foot; up to 4 cm length	3
64896	more than 4 cm length	3

CPT Procedure Code	Description	Group
64897	Nerve graft (includes obtaining graft), multiple strands (cable), arm or leg; up to 4 cm length	3
64898	more than 4 cm length	3
64901	Nerve graft, each additional nerve; single strand	2
64902	multiple strands (cable)	2
64905	Nerve pedicle transfer; first stage	2
64907	second stage	1

EYE AND OCULAR ADNEXA

EYEBALL

REMOVAL OF EYE

65091	Evisceration of ocular contents; without implant	3
65093	with implant	3
65101	Enucleation of eye; without implant	3
65103	with implant, muscles not attached to implant	3
65105	with implant, muscles attached to implant	4
65110	Exenteration of orbit (does not include skin graft), removal of orbital contents; only	5
65112	with therapeutic removal of bone	7
65114	with muscle or myocutaneous flap	7

SECONDARY IMPLANT(S) PROCEDURES

65130	Insertion of ocular implant secondary; after evisceration, in scleral shell	3
65135	after enucleation, muscles not attached to implant	2
65140	after enucleation, muscles attached to implant	3
65150	Reinsertion of ocular implant; with or without conjunctival graft	2
65155	with use of foreign material for reinforcement and/or attachment of muscles to implant	3
65175	Removal of ocular implant	1

CPT Procedure Code	Description	Group

REMOVAL OF FOREIGN BODY

65235	Removal of foreign body, intraocular; from anterior chamber or lens	2
65260	from posterior segment, magnetic extraction, anterior or posterior route	3
65265	from posterior segment, nonmagnetic extraction	4

REPAIR OF LACERATION

65270	Repair of laceration; conjunctiva, with or without nonperforating laceration sclera, direct closure	2
65272	conjunctiva by mobilization and rearrangement, without hospitalization	2
65275	cornea, nonperforating, with or without removal of foreign body	4
65280	cornea and/or sclera, perforating, not involving uveal tissue	4
65285	cornea and/or sclera, perforating, with reposition or resection of uveal tissue	4
65290	Repair of wound, extraocular muscle, tendon and/or Tenon's capsule	3

ANTERIOR SEGMENT

CORNEA

Excision

65400	Excision of lesion, cornea (keratectomy, lamellar, partial), except pterygium	1
65410	Biopsy of cornea	2
65420	Excision or transposition of pterygium; without graft	2
65426	with graft	5

Keratoplasty

65710	Keratoplasty (corneal transplant); lamellar	7
65730	penetrating (except in aphakia)	7
65750	penetrating (in aphakia)	7
65755	penetrating (in pseudophakia)	7
65770	Keratoprosthesis.	7

CPT Procedure Code	Description	Group
	ANTERIOR CHAMBER	
	Incision	
65800	Paracentesis of anterior chamber of eye; with diagnostic aspiration of aqueous	1
65805	with therapeutic release of aqueous	1
65810	with removal of vitreous and/or discission of anterior hyaloid membrane, with or without air injection	3
65815	with removal of blood, with or without irrigation and/or air injection	2
65850	Trabeculotomy ab externo	4
65855	Trabeculoplasty by laser surgery, one or more sessions	4
	Other Procedures	
65865	Severing adhesions of anterior segment of eye, incisional technique (with or without injection of air or liquid) goniosynechiae	1
65870	anterior synechiae, except goniosynechiae	4
65875	posterior synechiae	4
65880	corneovitreal adhesions	4
65900	Removal of epithelial downgrowth, anterior chamber eye	5
65920	Removal of implanted material, anterior segment eye	7
65930	Removal of blood clot, anterior segment eye	5
66020	Injection, anterior chamber; air or liquid	1
66030	medication	1
	ANTERIOR SCLERA	
	Excision	
66130	Excision of lesion, sclera	7
66150	Fistulization of sclera for glaucoma; trephination with iridectomy	4
66155	thermocauterization with iridectomy	4
66160	sclerectomy with punch or scissors, with iridectomy	2
66165	iridencleisis or iridotasis	4
66170	trabeculectomy ab externo in absence of previous surgery	4
66172	traveculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)	4
66180	Aqucus shunt to extraocular reservoir (eg, Molteno, Schocket, Denver-Krupin)	5
66185	Revision of aqueous shunt to extra ocular reservoir	2
	Repair or Revision	
66220	Repair of scleral staphyloma; without graft	3
66225	with graft	4
66250	Revision or repair of operative wound of anterior segment, any type, early or late, major or minor procedure	2
	IRIS, CILIARY BODY	
	Incision	
66500	Iridotomy by stab incision; except transfixion	1
66505	with transfixion as for iris bombe	1
	Excision	
66600	Iridectomy, with corneoscleral or corneal section; for removal of lesion	3
66605	with cyclectomy	3
66625	peripheral for glaucoma	3
66630	sector for glaucoma	3
66635	"optical"	3
	Repair	
66680	Repair of iris, ciliary body (as for iridodialysis)	3
66682	Suture of iris, ciliary body with retrieval of suture through small incision (eg, McCannel suture)	2
	Destruction	
66700	Ciliary body destruction; diathermy	2
66710	cyclophotocoagulation	2
66720	cryotherapy	2
66740	cyclodialysis	2
66761	Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessons)	2

CPT Procedure Code	Description	Group

ANTERIOR SEGMENT - LENS

Incision

66821	Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, YAG laser) (one or more stages)	2

Removal Cataract

66830	Removal of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid) with corneo-scleral section, with or without iridectomy (iridocapsulotomy, iridocapsulectomy) ***See page 9 for criteria.***	4
66840	Removal of lens material; aspiration technique, one or more stages ***See page 9 for criteria.***	4
66850	phacofragmentation technique (mechanical or ultrasonic) (eg, phacoemulsification), with aspiration ***See page 9 for criteria.***	7
66852	pars plana approach, with or without vitrectomy ***See page 9 for criteria.***	4
66920	intracapsular ***See page 9 for criteria.***	4
66930	intracapsular, for dislocated lens ***See page 9 for criteria.***	5
66940	extracapsular (other than 66840, 66850, 66852) ***See page 9 for criteria.***	5
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure) ***See page 9 for criteria.***	8
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (eg, irrigation and aspiration of phacoemulsification) ***See page 9 for criteria.***	8
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal ***See page 9 for criteria.***	6
66986	Exchange of intraocular lens ***See page 9 for criteria.***	6

CPT Procedure Code	Description	Group

POSTERIOR SEGMENT

VITREOUS

67005	Removal of vitreous, anterior approach (open sky technique or limbal incision); partial removal	4
67010	subtotal removal with mechanical vitrectomy	4
67015	Aspiration or release of vitreous, subretinal or choroidal fluid, pars plana approach (posterior sclerotomy)	1
67025	Injection of vitreous substitute, pars plana or limbal approach, (fluid-gas exchange), with or without aspiration	1
67030	Discission of vitreous strands (without removal), pars plana approach	1
67031	Severing of vitreous strands, vitreous face adhesions, sheets, membranes or opacities, laser surgery (one or more stages)	2
67036	Vitrectomy, mechanical, pars plana approach;	4
67038	with epiretinal membrane stripping	5
67039	with focal endolaser photocoagulation	7
67040	with endolaser panretinal photocoagulation	7

RETINA OR CHOROID

Repair

67107	Repair of retinal detachment, one or more sessions; scleral buckling (such as lamellar excision, imbrication or encircling procedure), with or without implant, may include procedures 67101, 67105	5
67108	with vitrectomy, any method, with or without air or gas tamponade, with or without focal endolaser photocoagulation, may include procedures 67101-67107 and/or removal of lens by same technique	7
67112	previously operated upon, any technique	7
67115	Release of encircling material (posterior segment)	2
67120	Removal of implanted material, posterior segment; extraocular	2
67121	intraocular	2

CPT Procedure Code	Description	Group
	Prophylaxis	
67141	Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage, one or more sessions; cryotherapy, diathermy	2
	Destruction	
67210	Destruction of localized lesion of retina (eg, maculopathy, choroidopathy, small tumors), one or more sessions; photocoagulation (laser or xenon arc)	1
67218	radiation by implantation of source (includes removal of source)	5
67227	Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), one or more sessions; cryotherapy, diathermy	1
67228	photocoagulation (laser or xenon arc)	2
	SCLERAL	
	Repair	
67250	Scleral reinforcement; without graft	3
67255	with graft	3
	OCULAR ADNEXA	
	EXTRAOCULAR MUSCLES	
67311	Strabismus surgery, recession or resection procedure (patient not previously operated on); one horizontal muscle ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	3
67312	two horizontal muscles ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	4
67314	one vertical muscle (excluding superior oblique) ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	4
67316	two or more vertical muscles (excluding superior oblique) ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	4
67318	Strabismus surgery, any procedure (patient not previously operated on), superior oblique muscle ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	4
67320	Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	4
67331	Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	4
67332	Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	4
67340	Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) ***For clients age 17 and younger.*** **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	4
	OTHER PROCEDURES	
67350	Biopsy of extraocular muscle **EXPEDITED PRIOR AUTHORIZATION REQUIRED FOR CLIENTS AGE 18 AND OLDER.**	1
	ORBIT	
	Exploration, Excision, Decompression	
67400	Orbitotomy without bone flap (frontal or transconjunctival approach); for exploration, with or without biopsy	3
67405	with drainage only	4
67412	with removal of lesion	5
67413	with removal of foreign body	5
67415	Fine needle aspiration of orbital contents	1

CPT Procedure Code	Description	Group
67420	Orbitotomy with bone flap or window, lateral approach (eg, Kroenlein); with removal of lesion	5
67430	with removal of foreign body	5
67440	with drainage	5
67450	for exploration, with or without biopsy	5
	Other Procedures	
67550	Orbital implant (implant outside muscle cone); insertion	4
67560	removal or revision	2
	EYELIDS	
	Incision	
67715	Canthotomy	1
	Excision	
67801	Excision of chalazion; multiple, same lid	2
67805	multiple, different lids	2
67808	under general anesthesia and/or requiring hospitalization, single or multiple	2
67830	Correction of trichiasis; incision of lid margin	2
67835	incision of lid margin, with free mucous membrane graft	2
67840	Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure	2
67850	Destruction of lesion of lid margin (up to 1 cm)	2
	Tarsorrhaphy	
67880	Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy;	3
67882	with transposition of tarsal plate	3
	Repair (Brow Ptosis, Blepharoptosis, Lid Retraction, Ectropion, Entropion)	
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	5
67902	frontalis muscle technique with fascial sling (includes obtaining fascia) **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	5
67903	(tarso) levator resection or advancement, internal approach **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	4
67904	(tarso) levator resection or advancement, external approach **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	4
67906	superior rectus technique with fascial sling (includes obtaining fascia) **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	5
67908	conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type) **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	4
67909	Reduction of overcorrection of ptosis **EXPEDITED PRIOR AUTHORIZATION REQUIRED.**	4
67911	Correction of lid retraction **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	3
67914	Repair of ectropion; suture **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	3
67916	blepharoplasty, excision tarsal wedge **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	4
67917	blepharoplasty, extensive (eg, Kuhnt-Szymanowski or tarsal strip operations) **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	4
67921	Repair of entropion; suture **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	3
67923	blepharoplasty, excision tarsal wedge **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	4
67924	blepharoplasty, extensive (eg, Wheeler operation) **EXPEDITED PRIOR AUTHORIZATION REQUIRED**	4
	Reconstruction	
67935	Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; full thickness	2
67950	Canthoplasty (reconstruction of canthus)	2

CPT Procedure Code	Description	Group
67961	Excision and repair of eyelid, involving lid margin, tarsus, conjunctiva, canthus, or full thickness, may include preparation for skin graft or pedicle flap with adjacent tissue transfer or rearrangement; up to one-fourth of lid margin	3
67966	over one-fourth of lid margin	3
67971	Reconstruction of eyelid, full thickness by transfer of tarsoconjunctival flap from opposing eyelid; up to two-thirds of eyelid, one stage or first stage	3
67973	total eyelid, lower, one stage or first stage	3
67974	total eyelid, upper, one stage or first stage	3
67975	second stage	3

CONJUNCTIVA

EXCISION AND/OR DESTRUCTION

68110	Excision of lesion, conjunctiva; up to 1 cm	2
68115	over 1 cm	2
68130	with adjacent sclera	2

CONJUNCTIVOPLASTY

68320	Conjunctivoplasty; with conjunctival graft or extensive rearrangement	4
68325	with buccal mucous membrane graft (includes obtaining graft)	4
68326	Conjunctivioplasty, reconstruction cul-de-sac; with conjunctival graft or extensive rearrangement	4
68328	with buccal mucous membrane graft (includes obtaining graft)	4
68330	Repair of symblepharon; conjunctivoplasty, without graft	4
68335	with free graft conjunctiva or buccal mucous membrane (includes obtaining graft)	4
68340	division of symblepharon, with or without insertion of conformer or contact lens	4

OTHER PROCEDURES

68360	Conjunctival flap; bridge or partial	2
68362	total (such as Gunderson thin flap or purse string flap)	2

CPT Procedure Code	Description	Group

LACRIMAL SYSTEM

Incision

68420	Incision, drainage of lacrimal sac (dacryocystotomy or dacryocystostomy)	3

Excision

68500	Excision of lacrimal gland (dacryo-adenectomy), except for tumor; total	3
68505	partial	3
68510	Biopsy of lacrimal gland	1
68520	Excision of lacrimal sac (dacryocystectomy)	3
68525	Biopsy of lacrimal sac	1
68530	Removal of foreign body or dacryolith, lacrimal passages	3
68540	Excision of lacrimal gland tumor; frontal approach	3
68550	involving osteotomy	3

Repair

68700	Plastic repair of canaliculi	2
68720	Dacryocystorhinostomy (fistulization of lacrimal sac to nasal cavity)	4
68745	Conjunctivorhinostomy (fistulization of conjunctiva to nasal cavity); without tube	4
68750	with insertion of tube or stent	4

Probing and/or Related Procedures

68810	Probing of nasolacrimal duct, with or without irrigation;	1
68811	requirimg general anesthesia	2
68815	with insertion of tube or stent	2

AUDITORY SYSTEM

EXTERNAL EAR

EXCISION

69110	Excision external ear; partial, simple repair	1
69120	complete amputation	2
69140	Excision exostosis(es), external auditory canal	2

CPT Procedure Code	Description	Group
69145	Excision soft tissue lesion, external auditory canal	2
69150	Radical excision external auditory canal lesion; without neck dissection	3
	REMOVAL OF FOREIGN BODY	
69205	Removal of foreign body from external auditory canal; with general anesthesia	1
69222	Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning)	3
	REPAIR	
69310	Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis due to trauma, infection)	3
69320	Reconstruction of external auditory canal for congenital atresia, single stage	7

MIDDLE EAR

	INCISION	
69420	Myringotomy including aspiration and/or eustachian tube inflation	3
69421	Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia	3
69424	Ventilating tube removal when originally inserted by another physician	1
69436	Tympanostomy (requiring insertion of ventilating tube), general anesthesia	3
69440	Middle ear exploration through postauricular or ear canal incision	3
69450	Tympanolysis, transcanal	1
	EXCISION	
69501	Transmastoid antrotomy ("simple" mastoidectomy)	7
69502	Mastoidectomy; complete	7
69505	modified radical	7
69511	radical	7
69530	Petrous apicectomy including radical mastoidectomy	7
69550	Excision aural glomus tumor; transcanal	5
69552	transmastoid	7
	REPAIR	
69601	Revision mastoidectomy; resulting in complete mastoidectomy	7
69602	resulting in modified radical mastoidectomy	7
69603	resulting in radical mastoidectomy	7
69604	resulting in tympanoplasty	7
69605	with apicectomy	7
69610	Tympanic membrane repair, with or without site preparation or perforation for closure, with or without patch	5
69620	Myringoplasty (surgery confined to drumhead and donor area)	2
69631	Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery), initial or revision; without ossicular chain reconstruction	5
69632	with ossicular chain reconstruction (eg, postfenestration)	5
69633	with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis (TORP))	5
69635	Tympanoplasty with antrotomy or mastoidotomy (including canalplasty, atticotomy, middle ear surgery, and/or tympanic membrane repair); without ossicular chain reconstruction	7
69636	with ossicular chain reconstruction	7
69637	with ossicular chain reconstruction and synthetic prosthesis (eg, partial ossicular replacement prosthesis, (PORP), total ossicular replacement prosthesis (TORP))	7
69641	Tympanoplasty with mastoidectomy (including canalplasty, middle ear surgery, tympanic membrane repair); without ossicular chain reconstruction	7
69642	with ossicular chain reconstruction	7
69643	with intact or reconstructed wall, without ossicular chain reconstruction	7
69644	with intact or reconstructed canal wall, with ossicular chain reconstruction	7
69645	radical or complete, without ossicular chain reconstruction	7
69646	radical or complete, with ossicular chain reconstruction	7
69650	Stapes mobilization	7

CPT Procedure Code	Description	Group
69660	Stapedectomy or stapedotomy with reestablishment of ossicular continuity, with or without use of foreign material	5
69661	with footplate drill out	5
69662	Revision of stapedectomy or stapedotomy	5
69666	Repair oval window fistula	4
69667	Repair round window fistula	4
69670	Mastoid obliteration	3
69676	Tympanic neurectomy	3
	OTHER PROCEDURES	
69700	Closure postauricular fistula, mastoid	3
69720	Decompression facial nerve, intratemporal; lateral to geniculate ganglion	5
69725	including medial to geniculate ganglion	5
69740	Suture facial nerve, intratemporal, with or without graft or decompression; lateral to geniculate ganglion	5
69745	including medial to geniculate ganglion	5

INNER EAR

INCISION AND/OR DESTRUCTION

69801	Labyrinthotomy, with or without cryosurgery or other nonexcisional destructive procedures or tack procedure; transcanal	5
69802	with mastoidectomy	7
69805	Endolymphatic sac operation; without shunt	7
69806	with shunt	7
69820	Fenestration semicircular canal	5
69840	Revision fenestration operation	5

EXCISION

69905	Labyrinthectomy; transcanal	7
69910	with mastoidectomy	7
69915	Vestibular nerve section, translabyrinthine approach	7

CPT Procedure Code	Description	Group
	INTRODUCTION	
69930	Cochlear device implantation, with or without mastoidectomy; **PRIOR AUTHORIZATION THROUGH LIMITATION EXTENSION REQUIRED**	7
69990	Use of operating microscope	5

DENTAL

0728D	Dental procedures	5

PROSTHETIC DEVICES

0501L	Prosthetic device/implant	Acquisition Cost

COLLAGEN IMPLANT

L8603	Collagen implant, urinary tract, per 2.5 cc syringe. Includes shipping and necessary supplies	$329.80

COCHLEAR IMPLANT

L8614	Cochlear device system **LIMITATION EXTENSION REQUIRED**	$14227.77
L8619	Coclear implant external speech processor; replacement. Bill for new replacement parts. **LIMITATION EXTENSION REQUIRED**	$6107.87
L8699	Prosthetic implant not otherwise specified. Bill only for refurbished replacement parts. Enter in box 19 of the HCFA claim form or in the *Comments* field for direct entry, magnetic tape, or EMC "refurbished speech processor." **LIMITATION EXTENSION REQUIRED**	B.R.

OTHER EXAM CODES

92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete	1
92502	Otolaryngologic examination under general anesthesia	1

CPT Procedure Code	Description	Group
G0105	Colorectal cancer screening; colonoscopy on individual at high risk	2

CORNEAL PROCESSING

V2785	Processing, preserving, and transporting corneal tissue	$1600

INTRAOCULAR LENSES

V2630	Anterior chamber intraocular lens	$330.42
V2631	Iris supported intraocular lens	$330.42
V2632	Posterior chamber intraocular lens	$330.42

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